Mark III
Employee Benefits

Employee
Benefits

Plan Year: July 1, 2016 - June 30, 2017

Arranged and Enrolled by Mark III Brokerage, Inc.

Table of Contents

Pre-Tax Products

After-Tax Products

For Your Reference

Mark III Employee Benefits

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/sp/ or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$1,500** person / **$3,000** family For out-of-network providers **$3,000** person / **$6,000** family Deductible per person applies when the employee is the only person covered under the plan. Does not apply to in-network preventive care & immunizations	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$3,500** person / **$5,000** family For out-of-network providers **$7,000** person / **$10,000** family Out-of-pocket limit for person applies when the employee is the only person covered under the plan.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com **or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	40% co-insurance	----------none----------
	Specialist visit	20% co-insurance	40% co-insurance	----------none----------
	Other practitioner office visit	20% co-insurance for chiropractor	40% co-insurance	Coverage for chiropractic care and rehabilitation services is limited to 60 days annual max.
	Preventive care/screening/ immunization	No charge	Not Covered/visit 40% co-insurance/screening Not Covered/immunizations	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carmark.com	Generic drugs	20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Non-preferred brand drugs	20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Specialty drugs (Includes oral contraceptives)	20% co-insurance/prescription (retail), 20% co-insurance/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery) Specialty medications must be ordered through Caremark Specialty Pharmacy 1-800-237-2767 Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------none----------
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	----------none----------
	Emergency medical transportation	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	20% co-insurance	20% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	50% penalty for no precertification.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	----------none----------
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	----------none----------
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	----------none----------
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	----------none----------
	Rehabilitation services	20% co-insurance	40% co-insurance	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	20% co-insurance	40% co-insurance	50% penalty for no precertification. Coverage is limited to 60 days annual max
	Durable medical equipment	20% co-insurance	40% co-insurance	----------none----------
	Hospice services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If your child needs dental or eye care	Eye Exam	$20 co-pay/exam	Reimbursement allowance up to $45/exam	Coverage is limited to one exam annual max
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Habilitation services • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight loss programs	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care • Hearing aids (Children) • Eye care (Children) • Routine eye care (Adult)		

Prevo Drug - Asheboro, 363 Sunset Avenue, Asheboro NC, 336-625-4311 offers all employees a cost effective alternative option for prescription drugs.

Five Points Medical Center, 300 Mack Road, Asheboro, NC, 336-625-1172, and Five Points Medical Center, 6215 US Hwy 64 E, Ramseur, NC, 336-824-2551 offers all employees a cost effective alternative option for health care.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,830
- **Patient pays:** $2,710

Sample care costs:

Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductible	$1,500
Co-pays	$0
Co-insurance	$1,180
Limits or exclusions	$30
Total	**$2,710**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,910
- **Patient pays:** $2,490

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductible	$1,500
Co-pays	$0
Co-insurance	$710
Limits or exclusions	$280
Total	**$2,490**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 4880130 **BenefitVersion:** 6
Plan Name: OAP High Deductible (Consumer Driven Plan)
Kit Track: SBM21674

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/sp/ or by calling 1-800-Cigna24

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers **$2,000** person / **$4,000** family For out-of-network providers **$4,000** person / **$8,000** family Does not apply to in-network preventive care & immunizations, in-network office visits, prescription drugs Co-payments don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, in-network prescription drugs - **$150** person / **$300** family Applies to brand name medications. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For in-network providers **$4,000** person / **$10,000** family For out-of-network providers **$8,000** person / **$20,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.myCigna.com **or call 1-800-Cigna24**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-Cigna24 or visit us at www.myCigna.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-Cigna24 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** of the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	40% co-insurance	----------none----------
	Specialist visit	$50 co-pay/visit	40% co-insurance	----------none----------
	Other practitioner office visit	$50 co-pay/visit for chiropractor	40% co-insurance	Coverage for chiropractic care and rehabilitation services is limited to 60 days annual max.
	Preventive care/screening/ immunization	No charge	Not Covered/visit 40% co-insurance/screening Not Covered/immunizations	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$4 co-pay/prescription (retail), $0 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Preferred brand drugs	$45 co-pay/prescription (retail), $90 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Non-preferred brand drugs	$60 co-pay/prescription (retail), $120 co-pay/prescription (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery)
	Specialty drugs (Includes oral contraceptives)	20% co-insurance/prescription $50 minimum / $400 maximum (home delivery)	Not Covered	Coverage is limited up to a 34-day supply (retail) and up to a 90-day supply (home delivery) Specialty medications must be ordered through Caremark Specialty Pharmacy 1-800-237-2767. Limited to a 30 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------none----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------none----------
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	----------none----------
	Emergency medical transportation	20% co-insurance	20% co-insurance	----------none----------
	Urgent care	$50 co-pay/visit	$50 co-pay/visit	Per visit co-pay is waived if admitted
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	50% penalty for no precertification.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------none----------

Common Medical Event	Services You May Need	Your Cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 co-pay/office visit and 20% co-insurance/other outpatient services	40% co-insurance	----------none----------
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
	Substance use disorder outpatient services	$50 co-pay/office visit and 20% co-insurance/other outpatient services	40% co-insurance	----------none----------
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	----------none----------
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	----------none----------
	Rehabilitation services	$50 co-pay/visit	40% co-insurance	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	20% co-insurance	40% co-insurance	50% penalty for no precertification. Coverage is limited to 60 days annual max
	Durable medical equipment	20% co-insurance	40% co-insurance	----------none----------
	Hospice services	20% co-insurance	40% co-insurance	50% penalty for no precertification.
If your child needs dental or eye care	Eye Exam	$20 co-pay/exam	Reimbursement allowance up to $45/exam	Coverage is limited to one exam annual max
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult) • Dental care (Children) • Habilitation services • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Weight loss programs	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care • Hearing aids (Children) • Eye care (Children) • Routine eye care (Adult)		

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-Cigna24. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: These numbers assume enrollment in individual-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,460
- **Patient pays:** $2,080

Sample care costs:	
Hospital charges (mother)	$2,700
Routine Obstetric Care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductible	$2,100
Co-pays	$50
Co-insurance	$1050
Limits or exclusions	$30
Total	**$3,230**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,360
- **Patient pays:** $1,040

Sample care costs:	
Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits & procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductible	$240
Co-pays	$470
Co-insurance	$0
Limits or exclusions	$280
Total	**$1,030**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 4880127 **BenefitVersion:** 6
Plan Name: Randolph County OAP Traditional
Kit Track: SBM21675

Randolph County
Effective July 1, 2016

Traditional PPO Health Plan

	1-34 Day Supply* At a retail pharmacy	90 Day Supply Through Mail
Generic Drugs	**$ 4**	**$ 0**
Preferred Brand	**$45**	**$ 90**
Non-Preferred Brand	**$60**	**$120**
Diabetic Supplies	**20%**	**20%**
OTC Smoking Cessation	**$ 5**	**$ 0**

$150 Deductible per member/$300 family max applies only to Brand Name Medications

**Not all medications are provided in exactly a 34 or 30 day supply. This can be due to packaging and/or quantity limits. The 1-34 or 30 day supply is indicated to show the range of days' supply allowed.*

Maximum Out of Pocket (MOOP): $2,000 single / $6,000 family
The plan year MOOP applies to pharmacy and medical. Each individual family member must meet the single MOOP unless the family MOOP has been met by any two or more covered family members. Once met, your covered prescriptions are paid at 100%. The deductible applies to the MOOP. Generic dispense as written penalties do not apply to the MOOP.

Consumer Driven Health Plan with HSA

Deductible: **$ 1,500 single/ $3,000 family**
Maximum Out of Pocket (MOOP): **$ 3,500 single/ $5,000 family**

The plan year deductible and Maximum Out of Pocket (MOOP) applies to pharmacy and medical. When the deductible is met your covered prescriptions are subject to a 20% coinsurance. Once your MOOP is met, your covered prescriptions are paid at 100%. The deductible applies to the MOOP and one family member or any combination of family members can meet the family deductible/MOOP. Generic dispense as written penalties do not apply to the MOOP.

Specialty Medication Copays are: 1-30 day supply at a 20% coinsurance ($50 min / $400 max) and are available as indicated below:

Specialty Medications: Specialty medications must be ordered through Caremark Specialty Pharmacy at 1-800-237-2767. Limited up to a 30 day supply and may require prior authorization or step therapy. Currently, step therapy categories include Autoimmune (Rheumatoid Arthritis) and Multiple Sclerosis.

Generic Policy: If you choose to buy the Brand name drug when a Generic equivalent is available, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug.

DRUGS COVERED**
- Legend Drugs (drugs that require a prescription) **Exceptions**: See Exclusion list below.
- Migraine Medications (quantity limits apply)
- Narcolepsy (prior authorization required)
- Topical Acne Agents (prior authorization required over age 35)
- ADD/ADHD (prior authorization required ages 19 and older)
- Compounded medication of which at least one ingredient is a legend drug at a participating pharmacy. Compounded medications equal to or exceeding $300 per script will require prior authorization.
- Contraceptives
- Impotency medications (limited to 4 per 30 days or 12 per 90 days)
- Stadol NS (limited to 2 per 25 days or 6 per 75 days)
- Toradol (limited to 20 per 25 days for retail and mail)

DRUGS COVERED(continued)**

- Hormone replacement rings (Estring & Femring) $150.00 for 90 day supply
- Diabetic Care: Insulin/Insulin pre-filled syringes, Agents/Strips, Disposable insulin needles/syringes/lancets
- Prescription Vitamins
- Smoking Cessation (Prescription and OTC)
- Oral/Intranasal/Topical Fentanyl Products (prior authorization required)
- Growth Hormones (prior authorization required)
- Androgens (prior authorization required)
- Antifungals (prior authorization required)
- Extended Release Controlled Substances-Opioid Analgesics (quantity limits apply)

EXCLUSIONS**

- Biological, blood products, serums, immunization agents and blood derivatives that are not officially classified as drugs
- Anti-obesity/Appetite suppression medications
- Anabolic Steroids
- Compounded prescriptions that use ingredients such as bulk chemicals, high cost powders, and compound kits
- Topical Analgesic Pain Patches
- Cosmetic agents (Anti-wrinkle agents, Depigmenting agents, Hair growth stimulants and removal products)
- Infertility medications
- OTC (Over the Counter) products unless listed above
- New to market drugs, including line extensions and new strengths until clinically reviewed
- Nutritional Supplements
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

****This is not an inclusive list but is a representation of the most commonly used medications. Contact customer service for specific drug coverage information.**

Your employer's plan is subject to the Affordable Care Act (ACA) which requires the coverage of a number of preventive items and services at 100% and ensures these items and services are not subject to deductibles or other limitations such as annual caps or limits. You can contact Customer Service if you have specific drug questions or register at www.caremark.com to check drug costs and coverage.

MEDICAL – TWO OPTIONS THRU CIGNA

Employees who participate in the biometric screenings and meet the wellness standard program criteria will receive the wellness incentive of $50.00 to offset the $50.00 employee monthly premium.

Premiums for Traditional PPO Plan 2016-2017

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee without wellness incentive
Employee Only	$570	$0	$50
Employee/Spouse	$1,020	$415	$465
Employee/Child(ren)	$900	$305	$355
Employee/Family	$1,150	$536	$586
*Monthly Premium includes county contribution for employee plus the cost of dependent coverage.			

Premiums for Consumer Driven Plan with Health Savings Account (HSA) 2016-2017

Coverage Category	*Monthly Premium	Cost to employee with wellness incentive	Cost to employee without wellness incentive
Employee Only	$570	$0	$50
Employee/Spouse	$970	$370	$420
Employee/Child(ren)	$870	$277.50	$327.50
Employee/Family	$1,095	$485	$535
*Monthly Premium includes county contribution for employee plus the cost of dependent coverage. County HSA contribution of $750, will be made at the beginning of the plan year, provided that the account has been set up by the employee.			

Eligibility

- ***CIGNA Health Plan (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Flexible Spending Accounts (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate after 6 months of employment.

- ***Dental Coverage (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Vision Coverage (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Accident Coverage (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Critical Illness Coverage (Pre-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Cancer Coverage (Pre-tax)***
  All full time employees under age 65 working 30+ hours per week are eligible to participate at annual enrollment only and contingent upon underwriting approval unless enrolled when first eligible.

- ***Short and Long Term Disability (After-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Basic Term Life and AD&D***
  Employer Paid $10,000 basic life: All full time employees working 30+ hours per week are eligible for this benefit on the first day of the month following 30 days of full time employment.

- ***Voluntary Term Life and AD&D (After-tax)***
  All full time employees working 30+ hours per week are eligible to participate on the first of the month after 30 days of full time employment.

- ***Whole Life (After-tax)***
  All full time employees working 30+ hours per week are eligible to enroll each year during annual enrollment only.

Pre-Tax Plans

Any full-time employee who works 30 or more hours per week will be eligible to participate on the first of the month after 30 days of full-time employment. All new employees who meet the eligibility requirements must turn in the election form before benefits become available.

The Insurance Premium Conversion Options

If you enroll in the coverages offered by your employer, your share of qualified premiums will be pre-taxed. That is, your payment will be made tax-free and be subject to the restrictions listed in the section under the heading IRS Pre-tax Rules and Limitations. You will not be able to change or suspend your participation throughout the year unless you experience a change in family status. Changes in family status are things such as:

- Marriage;
- Gaining a dependent;
- Divorce or legal separation;
- Losing a dependent;
- Termination or commencement of your spouse's employment;
- A change in you or your spouse's eligibility for coverage due to a change in employment.

If you have a change in family status and need to alter your participation, you should contact Human Resources within 30 days of the change. The change must be consistent with your change in family status. For example, you could not change to a lesser plan of coverage because you gained a dependent. You can always change your participation at the beginning of any plan year.

To review how the Premium Conversion Option impacts your paycheck, see Examples A & B on the following page.

Cigna Health Plan

The County offers employees group health insurance as administered through CIGNA to provide employee, employee/child(ren), employee/spouse, and employee/family coverage.

Examples of Premium Conversion

EXAMPLE A

You are single with no dependents/$2,000 gross monthly salary.

Without Cafeteria Benefits		With Cafeteria Benefits	
$2,000.00	Gross Salary	$2,000.00	Gross Salary
608.53	Federal, State, FICA	-58.63	Insurance Premiums
		-80.00	Medical Reimbursement Account
1,391.47			
-58.63	Insurance Premiums	1,861.37	**New Taxable Income**
-80.00	Out of Pocket Medical Expense	547.68	Federal, State, FICA
1,252.84	Spendable Income	1,313.69	**New Spendable Income**

You receive an increase in take-home pay of $60.85

EXAMPLE B

You are married with two dependents/$2,500 gross monthly salary.

Without Cafeteria Benefits		With Cafeteria Benefits	
$2,500.00	Gross Salary	$2,500.00	Gross Salary
-594.50	Federal, State, FICA	-356.32	Insurance Premiums
		-120.00	Medical Reimbursement Account
1,905.50		2,023.68	
-356.32	Insurance Premiums	2,023.68	**New Taxable Income**
-120.00	Out of Pocket Medical Expense	440.34	Federal, State, FICA
1,429.18	Spendable Income	1,583.34	**New Spendable Income**

You receive an increase in take-home pay of $154.16

* * * * * * * * * *NOTICE* * * * * * * * * *

The products described in this booklet are part of a Cafeteria Benefits Plan arranged by Mark III Brokerage for eligible Randolph County Government employees.

The Cafeteria Benefits Plan allows you to pay for certain insurance premiums before taxes are taken out of your paycheck. Paying for benefits in this method reduces your taxes and increases your take home pay.

The plan year is July 1, 2016 through June 30, 2017

All products described in this booklet are pre-taxed **EXCEPT:**

- **Aflac Critical Illness Plan**
- **AUL Long and Short Term Disability**
- **MetLife Term Life Insurance**
- **Texas Life Whole Life Insurance**

If you wish to add or make changes to your insurance coverage(s), please consult a Benefits Representative during your scheduled enrollment period. ***You will not be able to make any changes once the enrollment period is over*** unless you experience a qualified event (i.e., marriage, divorce, birth of a child, etc.)

All information in this booklet is a brief description of your coverage and is not a contract. Refer to your policy or certificate for each product for the exact terms and conditions.

Health Savings Account (HSA)

What is a Health Savings Account?

- An HSA is your personal account to manage that you set up through the local Credit Union.

- Contribute money **tax-free**
- Use money to pay for deductibles and unreimbursed medical expenses tax-free
- Offers Tax-Advantages savings
- Interest Earning Account

You must elect the Consumer Driven Plan to open an HSA Account

Randolph County will contribute $750 on July 1st to your HSA account set up with the Credit Union.

The money is your with no use it or lose it rules. Any money in the account is yours to use for qualified expenses even if you:

- Get married or divorced
- Move to another state
- Change employment
- Change medical coverage
- Become unemployed

You are eligible to open and contribute to an HSA if:

- You are covered by an eligible Consumer Driven Health Plan
- You are not covered by any other health plan
- You are not enrolled in Medicare, TRICARE, or TRICARE for Life
- You have not received VA benefits within the past 3 months
- You are not claimed as a dependent on someone else's tax return
- You are not covered by a health care FSA

Annual Contribution set by the IRS for 2016 - **$3,350** for Individuals and **$6,750** for families.

Those 55 years of age or higher but not entitled to Medicare benefits can fund an additional $1,000 per year "catch-up" contribution.

Flexible Benefit Administrators Spending Accounts

Plan Year: July 1, 2016 - June 30, 2017
Health Care Reimbursement Account Maximum: $2,500
Health Care Reimbursement Account Minimum: $240
Dependent Care Reimbursement Account Maximum: $5000
Waiting Period: 6 Months from Date of Full-Time Employment

Flexible Benefit Plan: The better you plan, the more you save!

It's more than a slogan. The Flexible Benefit Plan is a real solution to issues facing all of us. Simply stated, by taking advantage of tax laws, the Flexible Benefit Plan works with your benefits to save you money.

Your insurance programs are designed to help you and your family become financially secure as well as to protect you against the high cost of medical care including catastrophic events. However, almost everyone has a number of necessary, predictable expenses that are not covered by your insurance programs. The Flexible Benefit Plan will help you pay for these predictable expenses.

The Flexible Benefit Plan offers a unique way to help pay for some of your health care expenses.

The key to the Flexible Benefit Plan is that your eligible expenses are paid for with **Tax Free Dollars.** You will not pay any federal, state or social security taxes on funds placed in the Plan. You will save between, approximately, $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your federal tax bracket.

Using the Flexible Benefit Plan can save you a significant amount of money each year, however, it is important that you understand how the Plan works and how you can make the most of the advantages the Flexible Benefit Plan offers.

This chapter will help you understand the Flexible Benefit Plan. The chapter covers how the Plan works, describes the categories of the Plan, explains the rules governing the Plan, the reimbursement process and how you can elect to participate in the Flexible Benefit Plan. Prior to electing to participate in the Flexible Benefit Plan, it is important that you read and understand the **Rules and Regulations** section of this handbook.

After you read this material, if you have any questions please feel free to contact Flexible Benefit Administrators, Inc. at **(757) 340-4567 or (800) 437-FLEX (3539).**

Flex Note: *FLEX is authorized by Section 125 of the Internal Revenue Code.*

Health Care Reimbursement Account

The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out of pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The minimum you may place in this account for the plan year is $240. The maximum you may place in this account for the Plan Year is $2,500.

Examples of Eligible Health Care Expenses: Fees/Co-Pays/Deductibles:

- Acupuncture
- Ambulance hire
- Anesthetist
- Chiropractor
- Dental Fees
- Diagnostic
- Eye Exams
- Prescription Eye glasses
- Contact lenses
- Psychiatrist
- Hospital
- Laboratory
- Nursing
- Obstetrician
- Laser Eye Surgery
- Physician
- Psychologist
- Erectile dysfunction medication
- Sterilization Fee
- Surgery
- X-Rays
- Wheel Chair

Other Eligible Expenses:

- Prescription drugs
- Artificial limbs & breasts (only if reconstructive)
- Birth control pills, patches (e.g. Norplant)
- Orthopedic shoes/inserts
- Carpal tunnel wrist supports
- Incontinence supplies
- Vaccinations & Immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- Take-home screening kits (HIV, colon cancer)
- At home pregnancy test kits
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration
- Lactation supplies
- Smoking cessation programs and prescribed drugs designed to alleviate nicotine withdrawal
- Mileage, parking and tolls (you may be reimbursed $.24* a mile plus parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of medical charges)
- Orthodontic expenses (not for cosmetic purposes)

Note: Orthodontic Treatment is reimbursed according to your payment plan with the Orthodontist

For example: If your payment plan is set up to pay $100 a month for the orthodontic treatment, you can be reimbursed $100 a month for the payments that become due during the Plan Year.

This above list is compiled from IRS publication 502. If you are unsure that your expected medical expense will be eligible under tax code regulations, please call Flexible Benefit Administrators at (757) 340-4567 or (800) 437-FLEX before making your election for the Plan Year. IRS publication 502 can be ordered by calling the IRS at (800) 829-3676.

** Mileage reimbursement rate is based on IRS regulation and subject to change.*

Flex Note: *You can save between 28% and 38% in taxes on every $100 you place in the Plan.*

Changes To Over-The-Counter Drug Reimbursement Eligibility

Due to changes in legislation, over-the-counter drugs are no longer eligible for reimbursement without a prescription effective January 1, 2011.

Reimbursement

Reimbursement of over-the-counter drugs and medicines must be made via a paper claim with proper documentation. The Benefits Card can no longer be used with these items using IIAS (effective 1/1/11).

Eligible Over-the-Counter Expenses

Examples of eligible medications and drugs purchased in reasonable quantities **only with a doctor's prescription:**

- Antacids
- Pain relievers/aspirin
- Ointments & creams for joint pain
- Nicotine gum/patches to stop smoking
- First aid creams (Bactine, diaper rash)
- Allergy & sinus medication
- Cough & cold medications
- Laxatives
- Anti-diarrhea medicine
- Bug-bite medication

Over-the-Counter Expenses That Are Not Eligible

The following examples are OTC items that are not eligible and will not be reimbursed under any circumstances because the items are considered dietary supplements, toiletries, cosmetic or personal use items:

- Multi/Daily Vitamins
- Weight loss products/foods
- Face cream/moisteners
- Mouthwash/toothpaste
- Feminine hygiene products
- Deodorant
- Chapstick
- Suntan lotion
- Herbal/natural supplements
- Acne creams/face cleanser
- Medicated shampoo/soaps
- Toothbrushes (even if dentist recommends a special one)
- Eye/facial makeup/preparations
- Rogaine

Dual Purpose Drugs & Items

Expenses That Need Documentation From Your Physician To Be Eligible Through The Health Care Account

The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner's note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:

- Glucosamine/Chondroitin (for arthritis)
- OTC Hormone therapy(to treat menopausal symptoms)
- St. John's Wort (for depression)
- Pills for lactose intolerance
- Weight-loss drugs (to treat obesity)
- Prenatal vitamins
- Nasal sprays for snoring
- Fiber supplements (to treat a medical condition for a limited time)

Expenses for Improvement of General Health are not eligible for reimbursement even if a doctor prescribes the program. However, if the program is prescribed for a specific medical condition (e.g. Obesity, Emphysema), then the expense would be eligible. We must have a letter from your doctor on file for each Plan Year stating specifically what illness or disease is being treated or prevented and the length of time you will be required to use this treatment in order to reimburse for any of these types of expenses.

- Health Club Dues
- Weight Loss Programs
- Exercise classes
- Exercise equipment
- Wigs

Note: For Weight Loss Programs, only the cost of the program is an eligible expense. Any cost for food or food supplements is not an eligible expense.

Cosmetic expenses, prescriptions and treatments are not eligible. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an illness or disease. If cosmetic treatment is necessary to correct a deformity or abnormality, a personal injury or a disfiguring disease, it must meet IRS eligibility guidelines outlined in IRS publication 502 and will require a physician's letter of medical necessity.

Other expenses that are not eligible for reimbursement through the Health Care Account

Estimates for medical expenses that have not been rendered cannot be reimbursed. Medical services do not have to be paid for, however, the services must have been rendered during the Plan Year, to be eligible for reimbursement.

Premium Expenses for any insurance policies are not eligible for reimbursement through the Health Care Account. This includes contact lens insurance.

Expenses paid by an insurance company are not eligible for reimbursement through the Health Care Account. Only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

Claims Submission
Obtaining a reimbursement from your Health Care Account

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your employer's website (See sample Claim Form on page 42). You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Cash register receipts, credit card receipts and canceled checks alone are not eligible forms of documentation for medical expenses. These items are not considered third party receipts because they only reflect that payment has been made and do not provide the required information listed above. Prescription documentation must include the name of the prescribed medication.

Obtaining a reimbursement for over-the-counter items

For the purchase of over-the-counter medications and items with a prescription, cash register receipts will be accepted as documentation if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased. You must also send a copy of the Rx signed by a physician along with your claim form. If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

Note: In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care. FOR EXAMPLE: If you go to the doctor on June 26th and your Plan Year begins on July 1st, this expense is not eligible in the new Plan Year. Even if you pay for this expense after July 1st, the "date of service" was before the Plan Year began and therefore is not eligible.

The Health Care Account is a pre-funded account

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account allows you to pay for day care expenses for your dependents with tax-free dollars.

Eligibility Dependent

- A child under 13 who qualifies as a dependent on your Federal Income Taxes
- Any other dependents, including a disabled spouse, disabled children over age 13 and elderly parents, who depend on you for financial support, qualify as dependents for tax purposes, and are incapable of self care
- Please refer to Page 37 for the latest definition of a dependent, as revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005 (WFTRA)

Eligible Dependent Care Expenses

For dependent care expenses to be eligible for reimbursement, you must be working during the time your eligible dependents are receiving care. If you are married, your spouse must be:

- Working at the time the day care services are provided;
- A full-time student for at least five months during the year; or
- Mentally or physically disabled and unable to provide care for him or herself

Expenses for Kindergarten are not eligible for reimbursement since they are generally for education, and not for custodial care. In order for an expense to be eligible for reimbursement from the Dependent Care Reimbursement Account, the primary purpose for the care of the qualifying individual must be to assure the individual's well-being and protection. Dependent care must still be primarily for custodial care, not education, in order to qualify as an eligible employment-related expense from the Dependent Care Reimbursement Account.

Examples of Dependent Care Expenses

- Babysitters or Nannies that claim the child care as income on their taxes
- Licensed day care centers
- Private Preschool
- Before and after school care
- Day care for an elderly or disabled dependent

Expenses that would not be eligible through the Dependent Care Account

- Kindergarten (kindergarten & above is considered an educational expense)
- Days you or your spouse are not working, including sick leave, vacation days, and maternity leave
- Transportation, books, clothing, or entertainment (Note: These expenses will be covered if provided by the nursery school or day care center as part of its preschool care services. If these types of expenses are billed separately, they are not an eligible expense.)
- Care provider may not be a child of yours under the age of 19 or anyone you claim as a dependent for federal income tax purposes

- Babysitting for social events
- Overnight camp is not an eligible expense, only DAY CAMPS are eligible. Remember that this account is set-up so that you and your spouse are able to go to work and Overnight camp is 24-hour care.

Annual Maximum for the Dependent Care Reimbursement Account

Must Not Exceed The Lesser Of:

- $5,000 for one or more children ($2,500 if you are a married individual filing a separate tax return);
- Your wages or salary for the Plan Year; or
- The wages or salary of your spouse

If your spouse is either a full time student or is incapable of taking care of himself or herself then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, and $500 if there are two (2) or more children or dependents.

Using the Dependent Care Reimbursement Account versus filing for a tax credit on your taxes

Under current IRS regulations, you may be eligible to receive a tax credit for dependent care costs. You may claim a credit for dependent care, up to $3,000 for one child and $6,000 for two or more children, on your income taxes through the child care tax credit. However, through the Dependent Care Reimbursement Account you may set aside up to $5,000 per year, for one or more children, if you are married and filing a joint tax return or if you are a single parent. If you are married and filing separate tax returns, you may set aside only $2,500.

Typically, more money is saved by paying for dependent care through the FSA Dependent Care Reimbursement Account than by taking the dependent care credit on your tax return. This is because the total for federal, state, and FICA savings usually exceeds the dependent care credit. At taxable incomes greater than $14,000, participants will probably benefit more from taking reimbursement from the Flexible Benefit Plan. These assumptions are based on the inclusion of your state income tax.

You can also file for the tax credit while participating in the Dependent Reimbursement Care Account. If the amount you have placed through the reimbursement account does not meet the maximum allowed by the IRS, you can claim the difference between your Dependent Care deductions and the IRS maximum allowable expenses for the tax credit. You can claim a tax credit for any additional dependent care expenses incurred over the $5,000 maximum FSA limit up to the $6,000 child care tax credit limit on your taxes. You cannot claim the tax credit for any dependent care expenses paid from the Dependent Care Reimbursement Account. It is your responsibility to report the Dependent Care amount on your tax form 2441. The amount is listed on your W-2 under Dependent Care Benefit for the tax year.

If you are not sure about the eligibility of an expense, phone **Flexible Benefits Administrators at (757) 340-4567 or (800) 437-FLEX** or refer to IRS Publication 503: “Dependent Care Expenses”. This publication can be ordered by calling the IRS at (800) 829-3676.

Obtaining a reimbursement from your Dependent Care Reimbursement Account

To obtain a reimbursement from your Dependent Care Reimbursement Account you must complete a Claim Form. This claim form is available from your employer's website (See sample Claim Form on page 43). You must attach a receipt from the service provider which includes all of the following:

- Name of dependent receiving care
- Date(s) care was provided (must match Claim Form)
- Name of service provider
- Social Security or Tax I.D. number of the provider
- Amount of the charge

Note: Dependent care expenses can only be reimbursed after the care is provided. This means that advance payments of dependent care expenses cannot be made. FOR EXAMPLE: If you pay for a summer day camp for your child in May but the camp is the first week in July, we cannot reimburse you for this expense until July when the service is provided.

The Dependent Care Reimbursement Account is not a Pre-Funded Account

This means that you will only be reimbursed up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Flexible Benefit Administrators. You will be automatically reimbursed as additional deductions are taken and deposited into your account, until your entire claim is paid out.

The Benefits Card

The Benefits Card system allows you to pay for eligible pre-tax account expenses electronically at approved service providers and merchants. The Benefits Card provides you with instant access to your pre-funded Health Care Reimbursement Account for many common regular eligible expenses. You may also enjoy the convenience of paying for your childcare expenses (up to your account balance at the time of the "swipe") with the Benefits Card.

In order for you to get the most benefit from your Plan, we want to remind you of a few things concerning the Benefits Card:

- The Benefits Card works just like a debit card, only your "bank account" consists of the funds you elected to set aside in your pre-tax account(s). The card is not eligible for use at ATM's or other unqualified merchant locations. The card will be denied at the point of sale when use at an ineligible location is attempted. If an eligible provider does not accept MasterCard®, you must file a paper claim. When using the card at a self-service merchant terminal, you may select the credit or debit option (with your PIN).

- **How To Receive Your PIN:**
  The most cost effective way to provide a cardholder their PIN is to use the e-PIN delivery functionality. e-PIN delivery provides a simple and secure way for participants to view their PIN on the FBA WealthCare Portal. The FBA WealthCare Portal "My Cards" page provides a "View PIN" button next to each card number. Upon clicking "View PIN", FBA WealthCare Portal pops-up a new window containing the card's four digit PIN.

  Participants who have registered emails on file will be receiving notification of these changes and will be directed to retrieve their PIN from the FBA Wealthcare Portal. Detailed information will also be available on our website at www.flex-admin.com.

  Please note there will be an additional fee for those that choose to elect standard mail delivery PIN mailer* to the participant.
  *A PIN mailer is a piece of mail delivered to the employee containing the four digit card PIN. PIN mailers are sent separately from a card package in order to ensure that the card number and PIN do not arrive at the participant's house at the same time.

- Your card will be mailed to your home address via first class mail. Please allow up to two weeks for delivery of your card. If you do not receive your card two weeks after the start of your Plan Year, contact Flexible Benefit Administrators, Inc. so that a replacement card may be ordering. Any eligible expense incurred during that time may be reimbursed by mailing or faxing a claim form, and receipts to Flexible Benefit Administrators, Inc. following the customary claims filing procedure and cutoff times.

- When you receive your card, sign the back of the card prior to using it. Your card is activated upon the first swipe of the card.

- **Continue to save all receipts.** Flexible Benefit Administrators, Inc. may request them to verify expense eligibility.

- Flexible Benefit Administrators, Inc. will notify you by mail or e-mail if you incur an expense with the card that is or appears to be ineligible. Upon this notice you must send Flexible Benefit Administrators, Inc. a Transaction Substantiation Form with the corresponding itemized documentation within 40 days of the transaction. If you do not send in those required items, your card will be deactivated until the documentation is received.

- Your transaction will be denied for any amount greater than your health care reimbursement account annual election or your dependent care reimbursement account posted balance at the time of the “swipe”.

- You should notify Flexible Benefit Administrators, Inc immediately if your card is lost or stolen to deactivate the card. If your employment is terminated, you must surrender the card to your employer.

- You may monitor your account balance, transaction history or print a statement at any time, night or day on the Benefits Card website: **www.benefitspaymentsystem.com**.

- Additional information regarding the Benefits Card is available on our website: **www.flex-admin.com**. You may also download the Transaction Substantiation Form from our website under Participants; FBA Benefits Card; Forms.

Attention: Benefits Card Participants

Subject: Benefits Card Use

In light of IRS Rulings on Benefits Card use, it is important that you make yourself familiar with the cardholder agreement that accompanies your Benefits Card. Flexible Benefit Administrators, Inc. strongly suggests reviewing this document and making yourself and any dependent cardholders in your household aware of the terms.

Please be aware that upon receipt and signing of your Benefits Card, you as the cardholder and employee participant of the Plan are ultimately responsible for using the card only for eligible expenses. This also applies to any dependent that has use of the Benefits Card. By signing the back of the card, the employee/dependent is agreeing to the terms and conditions of this agreement.

As in the past, your responsibility as a participant in a tax-free plan is to use the card for eligible expenses ONLY (such as prescriptions, eyeglasses and medical co-pays, etc). As with paper claim submission, cosmetic prescriptions and procedures are not eligible for reimbursement. Please remember that each time you use your card you are certifying that the expense is eligible. If you have any doubt as to whether an expense is eligible, you should refer to your employee handbook, IRS Publication 502 or call our office to speak with one of our administrators. It is also your responsibility to acquire all documentation such as receipts, EOBs, etc. for the Plan Year’s expenses and to retain the documentation for the entire Plan Year. If you are aware that you have paid for an expense with the card that is ineligible it is your responsibility to notify Flexible Benefit Administrators, Inc. immediately. You will need to submit a Transaction Substantiation Form along with repayment for the amount of the ineligible expense.

Flexible Benefit Administrators, Inc., may request documentation to substantiate your Benefits Card transactions to determine eligibility of the expense. Please be aware that documentation for all over-the counter drugs will be required, as per IRS regulations.

In the event that your documentation shows ineligible expenses were paid with your Benefits Card, Flexible Benefit Administrators, Inc., will request that you re-pay the amount of the ineligible expense. If the payment is not received in the allotted time frame your card will be deactivated. Also, Flexible Benefit Administrators, Inc., may offset future claims and notify your employer. IRS rulings allow your employer to withhold this amount from your wages if necessary.

The Benefits Card is NOT PAPERLESS, just less paper and is a great convenience for the participants in the Plan, if used properly.

Please Note: **Eligible items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or over-the-counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. Effective July 1, 2009, the Benefits Card will no longer be accepted at merchants who have not implemented IIAS. Please visit www.sig-is.org and select "IIAS Merchants List" for the most recent list of IIAS merchants.**

Rules and Regulations

Claim Filing Dates

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit.

Common Errors To Avoid When Filing Claims

- The claim form is not signed
- Canceled checks, cash register receipts or credit card receipts are sent in place of receipts or bills from the provider of service
- Cash register receipts for OTC item(s) do not indicate the specific name of the product(s) purchased
- Claim form has not been completed
- Insufficient postage on envelope
- "Previous balance" statements or "payment on account" receipts submitted in place of actual date of service itemized bills or receipts

Your claim form may be returned to you or delayed in processing for improper or insufficient documentation. If you have questions about your claims, you may contact Flexible Benefit Administrators, Inc. at **(757) 340-4567** or (**800) 437-FLEX (3539),** from 8:30 a.m. to 5:00 p.m., Monday through Friday.

Reimbursing The Provider Of Service

All reimbursements will be sent to you directly. After receiving payment from your account, you are responsible for paying your providers.

Eligible Dependents

An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer. The following qualifying criteria now apply. To be a "dependent child": the individual is a child to the participant, and the individual doesn't turn 27, regardless of any other status by the end of the taxable year.

In addition, the following qualifying criteria apply to be a "dependent relative": the individual has a specific family type relationship to the taxpayer, the individual is not a qualifying child of any other taxpayer, the individual receives more than half of his or her support from the taxpayer, and the individual's annual gross income is less than the Section 151 limit ($3,900 for 2013; this criteria does not apply to health plans).

Run-out Period for filing claims

You have the entire Plan Year plus 90 days to file all claims that were incurred during the Plan Year. All claims must be received in the office of Flexible Benefit Administrators, Inc. by 5:00 p.m. on the 90th day, following the end of your Plan Year. Therefore, for the Plan Year 07/01/14 – 06/30/15 all claims must be in our office by 5:00 p.m. on September 28, 2015. If claims are not received during this time frame for expenses incurred during the Plan Year, your remaining funds will be forfeited. (Remember "90 days" does not mean 3 months and "received in the office" does not mean the day it was postmarked). **Please, do not delay; complete your claims early.**

Changes In Your Election

No, generally you cannot change the elections you have made after the beginning of the PLAN YEAR. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the "change in status." Currently, Federal law considers the following events to be "changes in status":

- Marriage, divorce, death of a spouse, or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: Termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance;
- A change in place of residence of you, your spouse, or your dependent. This applies ONLY to Dependent Care and ONLY if that change in residence results in a change of dependent care service provider and its cost.

These rules on change due to cost or coverage do not apply to the Health Care Reimbursement Plan, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance.

You may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.

To make a change in your elections, a STATUS CHANGE FORM must be completed within 30 days of the event. Flexible Benefit Administrators, Inc. or your benefits contact person will determine if your requests for an election change meets IRS Regulations.

Transferring Funds Between Accounts

IRS regulations do not allow money to be transferred between reimbursement accounts. If you elect funds to be placed in your Health Care Account, you must submit eligible medical expenses to be reimbursed from these funds. This IRS regulation also applies to the Dependent Care Reimbursement Account.

Termination Of Employment

If you have funds in your Health Care Account and you submit receipts for expenses incurred prior to your termination, you can be reimbursed for funds remaining in your account up to your annual election. However, if you have money left in your Health Care Account and do not have receipts for expenses incurred prior to your termination, you cannot be reimbursed for the money remaining in your account unless you elect to participate in the federal program, COBRA. If you elect to participate in COBRA, you will need to continue to set aside dollars on an after tax basis to be deposited into your Health Care account. You can receive information concerning this program from the contact person in your company.

Your Dependent Care Reimbursement Account functions differently. If you have funds remaining in these accounts, this money will be reimbursed to you if appropriate receipts are submitted. You can receive reimbursement for expenses incurred during the Plan Year if receipts are submitted within the Plan Year and before the end of the 90-day grace period following the Plan Year end.

Effect On Social Security Benefits

As you are not paying social security tax on the portion of your income that has been placed in the Plan, your social security benefits may be slightly reduced. We suggest putting part of your tax savings into your Employer's Retirement Program or some other savings vehicle.

Account Balances

You may call Flexible Benefit Administrators, Inc. at (**757) 340-4567** or **(800) 437-FLEX (3539)** from 8:30 a.m. to 5:00 p.m., Monday through Friday, to check your account balances. You may also access your personal account information at your convenience via our secure website: **www.flex-admin.com.** Each reimbursement check stub will show your contributions, request for reimbursements, and disbursements for each account. It will also show your annual election and the balance to request by the end of the Plan Year for each account. A reminder letter will be sent the month prior to the end of the Plan Year if you have funds left in your accounts.

Changes to the Use-It-Or-Lose-It rule

What has changed?

The IRS amended the use-it-or-lose-it rule to allow a limited amount of unused funds to rollover at the end of the plan year. Although the IRS notice calls it "carryover", we call it "rollover" to match our plan feature.

How much can rollover?

Up to $500 in unused funds can rollover into the following plan year.

Does the new rollover rule apply to dependent care FSAs?

No. Your dependent care FSA is independent of this health FSA ruling and remains unaffected.

If rollover is offered, does this change the $2,500 maximum annual election?

No. For example: If the full $500 were to rollover into the following plan year and you elected to contribute the full $2,500 in that year, you would have a total of $3,000 available for reimbursement of eligible healthcare.

Does the rollover option affect the run-out period?

No. You will still be able to file claims during the run-out period for expenses incurred **during** the plan year.

Do I have to elect a health FSA in the plan year into which funds are rolled over?

No, but you will be limited to only the rollover amount for healthcare expenses in the next plan year. Although you may not be contributing in the rollover year, you remain a participant until your rollover funds are exhausted.

How is the rollover amount calculated?

The carryover amount is determined after all expenses have been reimbursed for that plan year (after the end of the plan's run-out period). For example, if a plan has a run-out period that ends on March 31 of the following plan year, the amount rolled over for a plan year is equal to the amount from that plan year remaining in the participant's health FSA after March 31 (up to the rollover amount of $500). Any unused amount in excess of $500 is forfeited.

How long do I have to use my rollover funds?

According to the IRS ruling, "The carryover of up to $500 may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over." The expense must be incurred by the last day of the plan year into which the funds were rolled over. However, if you terminate employment, then you are only eligible for reimbursement for claims with dates of service on or before your termination date.

In what order are funds utilized for new claims?

According to the guidance examples, current year funds should be used prior to any rollover funds being used.

Can I use my benefits debit card to access rollover funds?

Yes. The debit card will access current year funds and then rollover funds.

Are rollover amounts cumulative?

No. The rollover amount from one year to the next is capped at $500. For example, if you have $500 that rolls over from 2014 to 2015, and then you contribute $500 in 2015, but do not file any claims for 2015, the rollover amounts cannot be combined to $1,000 to be carried forward into 2016 —only $500 can be carried forward.

What happens to the rollover if my employment is terminated?

If you leave the company mid-plan year, you are not eligible to receive rollover funds. However, you have a run-out period to submit claims within the dates of service for which you were eligible for reimbursement.

The benefits of the new FSA rule:

- Rollover up to $500 of unused funds to the following plan year
- The rollover amount does not affect the following year's maximum contribution amount – you can still contribute up to the maximum allowance of $2,500
- Maximize your tax savings by increasing your contribution
- The new rule does not affect run-out periods
- Your entire annual election is still available at the beginning of the plan year

Estimating Your Expenses

This worksheet will help you determine your annual expenses for each reimbursement account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan. Keep in mind, your maximum annual elections cannot exceed $2,500 for health care and $5,000 for dependent care.

Estimating Your Qualifying Health Care Expenses

Medical deductibles _____
Medical co-payments _____
Prescription drugs _____

Vision Exams, Glasses, Contacts _____

Dental/Orthodontia _____
Routine exams and physicals _____
Over-the-counter expenses _____

Total Estimated Health Care Expenses for the Plan Year (Max. $2,500) _____

Estimating Your Dependent Care Expenses

Child day care expenses _____
Pre-School expenses _____
Summer Day Camp expenses _____
Adult day care expenses _____
Other eligible expenses _____

Total Estimated Dependent Care Expenses for the Plan Year (Max. $5,000) _____

Sample Medical Flexible Benefit Plan – Claim Form

Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

FSA Medical Reimbursement Claim Form

How to File

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

Print Form

☐ Check box if this is to offset previously submitted ineligible expense(s).

To submit by e-mail, Print Form and sign. E-mail form along with documentation to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

Account Holder Information

Employee Name (Print name)

Social Security Number or Employee ID #

E-Mail address
(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

Claims For Out-Of-Pocket Expense

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

-Please indicate your qualifying expenses below. DO NOT include expenses reimbursed by any other source.
-Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.
-Be sure to keep your original receipts, bills, etc. for your records.

	Person treated and Relationship	Type of Eligible Expense	Date of Treatment	$ Amount of Expense
1				$ 0
2				$ 0
3				$ 0
4				$ 0
5				$ 0
6				$ 0

Note: Orthodontia expenses are reimbursed as designated by the provider. We must have a copy of your orthodontic contract on file.

Total $ 0

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

I request reimbursement from my Health Flexible Spending Account (Health FSA) for the amounts listed above. To the best of my knowledge, my statements are complete and true. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source and that the expense is not for cosmetic purposes. I understand that I cannot use expenses reimbursed through the Health FSA account as tax deductions when filing income tax returns. I further certify that the expenses submitted on this claim are for myself and/or my qualified tax dependents for health coverage purposes as defined under the Internal Revenue Code 125.

I, the participant, further certify that the expense(s) noted above have not been previously paid for by use of my Benefits Card.

Employee's Signature:

Date

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Sample Dependent Care Flexible Benefit Plan – Claim Form

FlexibleBenefit ADMINISTRATORS

Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

FSA Dependent Care Reimbursement Claim Form

How to File

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

Print Form

To submit by e-mail, Print Form and sign. E-mail form along with documentation to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

Account Holder Information

Employee Name (Print name)

Social Security Number or Employee ID #

E-Mail address
(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

Claims For Out-Of-Pocket Expense

INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

The following information is REQUIRED: Name of Provider, Dates of Service and the expense amount; a receipt and bill. NOTE: Cancelled checks and/or credit card statements/receipts are not sufficient proof of your claim.

1

Name of Dependent

Service Start Date

$ 0

Amount of Expense

Name of Provider

Service End Date

Provider's Social Security Number or Tax ID #

2

Name of Dependent

Service Start Date

$ 0

Amount of Expense

Name of Provider

Service End Date

Provider's Social Security Number or Tax ID #

Total $ 0

YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Flexible Spending Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. Any claimed Dependent Care expenses were provided for my dependent under the age of 13 or for my dependent who is incapable of self care. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature:

Date

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Accessing Your Flex Account Online

Get CONNECTED with your account…wherever, whenever.

Introducing... our convenient participant web site! With the online WealthCare Portal you can view your account status, submit claims and report your benefits card lost/stolen right from your computer.

Follow the simple steps outlined below to establish your secure user account.

- Get started by visiting **www.mywealthcareonline.com/fba/** and click the participant account log-in link.
- You will be redirected to the participant log-in page. Then click **Register** in the top right hand corner
- Follow the prompts to create your account.
    - Name
    - E-mail Address
    - Employee ID (Your SSN or company assigned ID number or your benefits card number)
    - Employer ID **(FBARAN)**
- Once completed you will be automatically logged-in to your account.

Click and Submit with Online Claims…It's that easy

- Get started by visiting www.flex-admin.com and click the participant account log-in link.
- Log into your account with your username and password.
- Click on **My Expenses** and follow the prompts to submit your claim.
    - Complete online claim form
    - Upload your supporting documentation
    - Click Submit
- Once completed your claim will be posted immediately to your account and will be reviewed within 2-3 business days.

Administered by
Flexible Benefit Administrators, Inc.
509 Viking Drive, Suite F
P.O. Box 8188
Virginia Beach, VA 23450
(757) 340-4567 or (800) 437-FLEX (3539)
Fax: (757) 431-1155
FlexDivision@flex-admin.com
www.flex-admin.com

Ameritas Dental High Plan

Effective Date: July 1, 2016

Combined Calendar Year Deductible

$50.00 per individual for Type 2 (Basic) and Type 3 (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

Type 1 - Preventive and Diagnostic

Type 1 benefits are payable at 100% U&C**. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

Type 2 - Basic Procedures

Type 2 benefits are payable at 80% U&C**. $50.00 deductible applies.

- Sealants (Under 17)
- Limited Exams
- Denture Repair
- Oral Surgery - Complex and Simple Extractions
- Anesthesia
- Restorative Amalgam & Resin (excluding inlays & crowns)

Type 3 - Major Procedures

Type 3 Benefits are payable at 50% U&C**. $50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Crown Repair
- Restorative - Crowns
- Prosthodontics - Fixed Pontics or Abutments
- Prosthodontics - Removable Dentures, Partials

Orthodontia

Paid at 50% U&C** with a $1,000 lifetime maximum. No deductible applies.
Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

Late Entrant: There is a 12 month waiting period on all services except for cleanings, exams and fluoride applications for employees who do not enroll when **first eligible for coverage**. The waiting period will be waived for employees who enroll when first eligible.

***Usual and Customary Charge*

Annual Maximum Benefit

- Type 1, Type 2, and Type 3 Procedures - $1,000* per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carryover doesn't apply)

*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements, you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1,000. This benefit allows you to accumulate up to a $2,000 annual dental maximum!

Dental Exclusions (deferment Period)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded. **EXCEPTIONS** to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Eligible Employees

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26.

Predetermination of Benefits

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

Certificate of Insurance

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

Section 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

Limitations / Exclusions (This is not a complete List)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he/ she is eligible for benefits under Worker's Compensation Act or similar laws.

This insurance is underwritten by Ameritas Life Insurance Corporation.

For Claims / Customer Service Questions
call Ameritas At: (800) 487-5553

Ameritas High Plan Dental Rates

Employee Only	$32.32
Employee/Spouse	$66.38
Employee/Child(ren)	$73.80
Employee/Family	$107.86

AMERITAS
LIFE INSURANCE CORP.

Ameritas Dental PPO Plan

Effective Date: July 1, 2016

To access the full value of the PPO Plan, you are strongly encouraged to utilize In-Network providers. If you are not planning to utilize an In-Network Provider, do not enroll in the PPO Plan as your Out-of-Network benefits will be significantly reduced.

Combined Calendar Year Deductible

$50.00 per individual for Type 2 (Basic) and Type 3 (Major) Procedures (3 times family limit). After the date that 3 members of a family have each satisfied their individual deductible, the entire deductible or any remaining portion of the deductible for any family member will be waived for the rest of that calendar year.

Type 1 - Preventive and Diagnostic

Type 1 benefits are payable at 100% MAC*. No deductible applies.

- Evaluations (Two per benefit period)
- Cleanings (Two per benefit period)
- Fluoride for Children (Under age 19)
- Space Maintainers
- Radiographs (X-rays)
- Bitewings (Two per benefit period)

Type 2 - Basic Procedures

Type 2 benefits are payable at 80% MAC*. $50.00 deductible applies.

- Sealants (Under 17)
- Denture Repair
- Oral Surgery - Complex and Simple Extractions
- Limited Exams
- Anesthesia
- Restorative Amalgam & Resin (excluding inlays & crowns)

Type 3 - Major Procedures Type 3 Benefits are payable at 50% MAC*. $50.00 deductible applies.

- Endodontics (Root Canal)
- Periodontics (Gum Disease)
- Prosthodontics - Removable Dentures, Partials
- Restorative - Crowns
- Crown Repair
- Prosthodontics - Fixed Pontics or Abutments

Orthodontia

Paid at 50% U&C** with a $1,000 lifetime maximum. No deductible applies.
Benefits will be payable when a Covered Expense is incurred. The Covered Expenses for a program are based on the estimated cost of the insured's program. They are pro-rated by quarter (three month periods) over the estimated length of the program, but not for more than eight quarters. The last quarterly payment for a program may be changed if the estimated and actual cost of the program differ.

***Important Note: Late Entrant Notice*:** There is a 12 month waiting period on all procedures except cleanings, exams, and fluoride treatments, unless the employee (and/or dependents) enrolled in the plan when they were FIRST eligible to participate.

**Percentage Paid based on Maximum Allowable Charge*

** Percentage Paid based on *Usual and Customary Charges*

Annual Maximum Benefit

- Type 1, Type 2, and Type 3 Procedures - $1,000 per calendar year per person.
- Orthodontia Procedures - $1,000 Lifetime per person (carryover doesn't apply)

*This plan includes a **maximum carryover** for dental. Each insured (employee and/or dependent) will qualify for a dental maximum carryover if they:

1. Visit a dentist between January 1 and December 31 of each year.
2. Submit a claim for a covered procedure prior to March 1 of the following year.
3. Total dental benefits paid for the calendar year must be less than $500.

If you meet all 3 requirements then you will be eligible for the Annual Maximum Carryover benefit. This benefit will provide you with an additional $250 towards your annual dental maximum for the following year. In future years, if you continue to meet these requirements, you will continue to see an increase in your annual maximum by $250 until you have reached an annual maximum carryover limit of $1,000. This benefit allows you to accumulate up to a $2,000 annual dental maximum!

Dental Exclusions (deferment Period)

During the first 36 months following your or your dependent's Dental Coverage Effective Date, the initial placement of dentures, partial dentures, or bridges, if it includes the replacement of teeth all of which are missing prior to the effective date. (For currently covered insureds, Ameritas will use the employees Date of Hire to determine the 36 month period.) This exclusion will not apply if the prosthesis replaces a sound natural tooth which is extracted while the patient is insured under this Dental Coverage and which is replaced within 12 months of the extraction. During the first 36 months of coverage, the replacement of bridges, partial dentures, dentures, inlays or crowns is excluded.

EXCEPTIONS to this exclusion will be made if the replacement is made necessary by: a) accidental bodily injury to sound natural teeth (chewing injuries are not considered accidental bodily injuries), or b) the extraction of a sound natural tooth provided the replacement is completed within 12 months of the date of the injury or extraction.

Eligible Employees

You are eligible for insurance if you are a full-time active employee working at least 30 hours per week.

Eligible Dependents

Provides Coverage On:

- Your Spouse
- Children up to age 26.

Predetermination of Benefits

A treatment plan MAY be filed if a proposed course of treatment will exceed $200.00. With this information, Ameritas can determine the benefits payable under this policy prior to the work actually being done. It will give the insured the amount payable, along with an idea of the out of pocket expense.

Coordination of Benefits

If you or any of your dependents incur charges which are covered by any other group plan, the benefits of this plan will be coordinated with the benefits of the other plan so that the total benefits received are not greater than the charges incurred.

Certificate of Insurance

The Certificate of Insurance issued to you describes in detail the benefits and limitations of this plan. This brochure is for general information only.

Section 125

This policy is provided as part of the Policyholder's Section 125 Plan. Each member has the option under the Section 125 Plan of participating or not participating in this policy.

A member may change their election only during an annual election period, except for a change in family status. Examples of such events would be marriage, divorce, birth of a child, death of a spouse or child or termination of employment. Please see your plan administrator for details.

Orthodontia Limitations (This is not a complete list)

No benefit is payable for expenses incurred:

- In connection with a Treatment Program which was begun before the individual became insured for orthodontic benefits.
- During any quarter of a Treatment Program if the individual was not continuously insured for orthodontic benefits for the entire quarter.
- After the individual's insurance for orthodontic benefits terminates.

Limitations / Exclusions (This is not a complete List)

- For any treatment which is for cosmetic purposes. Facings on crowns or pontics behind the 2nd bicuspid are considered cosmetic.
- Charges incurred prior to the date the individual became insured under this plan, or following the date of termination of coverage.
- Services which are not recommended by a dentist or which are not required for necessary care and treatment.
- Expenses incurred to replace lost or stolen appliances.
- Expenses incurred by an insured because of a sickness for which he/she is eligible for benefits under Worker's Compensation Act or similar laws.

Commonly Asked PPO Questions

Do I have to use an Ameritas PPO provider?

No, employees and their covered dependents may utilize any licensed dental provider that they choose.

Please note, there is no difference in the coinsurance, deductible, and maximums on either plan whether a PPO provider is utilized or not.

Why would I use an Ameritas PPO provider?

By using a PPO provider:

- A Participating Provider is a dentist who has entered into an agreement to provide services to insured members of Ameritas' plans for at a specific fee. Any insured member who chooses to go to a PPO provider will receive this discounted fee for procedures performed by that provider.
- As part of their contractual agreement with Ameritas, the PPO provider cannot "back-bill" the patient for the difference between the dentists' normal charges and the discounted fees that the dentist agreed to charge as an Ameritas PPO provider.
- PPO providers are required to file the claim for the patient.
- PPO providers are required to wait for reimbursement from Ameritas before billing the patient for any balances owed for deductibles, coinsurance, any amounts exceeding the annual maximum benefits, etc.

PPO panels are available in many areas; please visit the Ameritas website at www.ameritasgroup.com to search for a provider in your area.

What happens if I don't use an Ameritas PPO provider?

For members that do not want to utilize an Ameritas PPO provider, or if a PPO provider is not available in your area:

Randolph County Government wants employees to have options regarding their choice of providers. In addition, we want to ensure that employees that utilize non-panel providers receive exceptional benefits that reimburse claims for non-panel providers in the most optimal way. Non-panel providers can charge their standard fees for any service. **However, the amount Ameritas allows for each procedure for non-panel provider utilizes 85th percentile of U&C – which is considered to be one of the highest reimbursement levels in the industry. This means that 8.5 out of 10 dentist's charges will fall within the amount that Ameritas allows for each procedure.** In doing so, employees can feel comfortable that very little back billing will occur due to the amounts allowed by the plan.

Non-panel providers have no specific requirements regarding filing of claims. However, we have found that many dentists will assist the patient with the paperwork needed to file the claim. If a dentist is not willing to file the claim on the patient's behalf, the patient can simply attach the dentist's bill to a claim form that includes the patient's name and identification number, and fax or mail the claim to Ameritas for processing. Ameritas will process the claim, typically within 7-10 working days. Claim payment can be made to the patient or directly to the dentist if noted on the claim form. The patient can use Ameritas' claim forms which are available in the Benefit's Department or on Ameritas web site OR the patient can use any generic claim forms that the dental office may have available. Filing claims is fast and easy with Ameritas!

If you have any questions about PPO or the plan, please call:
Ameritas Group Claims Department at 800-487-5553

Or, visit the Ameritas website at:
www.AmeritasGroup.com

Ameritas PPO Plan Dental Rates

Employee Only	$25.98
Employee/Spouse	$52.80
Employee/Child(ren)	$57.78
Employee/Family	$84.60

AMERITAS
LIFE INSURANCE CORP.

Superior Vision Plan

Effective Date: July 1, 2016

Outline of Benefits – Gold Preferred Plan with Materials Discount

Copayment: ***$10.00 Exam Copayment***
$10.00 Materials Copayment
$25.00 Contact Lens Fitting Fee

How to Use the Plan

Welcome to Superior Vision's vision plan. Superior Vision provides primary vision care benefits including eye examinations, prescription eyewear, and contact lenses through a broad-based provider network consisting of ophthalmologists, optometrists, and opticians. The plan also contracts with a large number of national and regional optometric chain locations.

Your first step should be to choose an eye care provider, or ensure that your current provider is part of the Superior Vision network. Go to www.superiorvision.com and click on "Locate a Provider" for an updated list. You will learn about "in-network" and "out-of-network" providers – it is an important distinction when receiving your benefits. You will also learn more about how to use your benefits, as well as the discounts that are available to you.

Remember that a routine eye exam is important not only for correcting vision problems, but for maintaining healthy eyes and overall health wellness. Superior Vision eye care providers are trained to test for and diagnosis a variety of health issues – not just eye problems. Take the time to get to know your vision plan, and start experiencing healthy eyes and healthy living.

Benefits

	Frequency	*In-Network[1]*	*Out-of-Network[1]*
Comprehensive Eye Exam			
Ophthalmologist	12 Months	Covered in Full	Up to $44.00
Optometrist	12 Months	Covered in Full	Up to $39.00
Standard Lenses (Per Pair):			
Single Vision	12 Months	Covered in Full	Up to $34.00
Bifocal	12 Months	Covered in Full	Up to $48.00
Trifocal	12 Months	Covered in Full	Up to $64.00
Lenticular	12 Months	Covered in Full	Up to $88.00
Contact Lenses (Per Pair)[2]			
Medically Necessary	12 Months	Covered in Full	Up to $210.00
Cosmetic (Elective)[3]	12 Months	Up to $150.00	Up to $100.00
Contact Lens Fitting[4]			
Standard	12 Months	Covered in Full	Not Covered
Specialty	12 Months	Up to $50.00	Not Covered
Frames-Standard[3]	24 Months	Up to $150.00	Up to $77.00

[1] All in-network and out-of-network allowances are at the retail value.

[2] Contact lenses are in lieu of eyeglass lenses and frames benefits.

[3] The insured is responsible for paying any charges in excess of this allowance.

[4] Standard contact lens fitting fee applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

Discount Features

Look for providers in the Provider Directory who accept discounts; please verify their discounts prior to service.

Discounts on Covered Materials

Frames:	20% off amount over allowance
Lens options:	20% off retail
Progressives:	20% off amount over retail lined trifocal lens, including lens options

The following options have out-of-pocket maximums[5] on standard plastic single vision lenses, and select options are available on standard bifocal and trifocal lenses. Out-of-pocket maximums are not available on premium options or progressives.

Maximum Member Out-of-Pocket

	Single Vision	Bifocal & Trifocal
Scratch coat	$13	$13
Ultraviolet coat	$15	$15
Tints, solid or gradients	$25	$25
Anti-reflective coat	$50	$50
Polycarbonate	$40	20% off retail
High-index 1.6	$55	20% off retail
Photochromic	$80	20% off retail

Discounts on Non-Covered Exam and Materials

Superior Vision offers discounts on an unlimited number of materials after the member has exhausted their covered benefit.

Exams, frames, and prescription lenses:	30% off retail
Lens options, contacts, other prescription materials:	20% off retail
Disposable contact lenses:	10% off retail

Refractive Surgery

Superior Vision has a nationwide network of refractive surgeons and partnerships with leading LASIK networks (QualSight, TruVision, and LasikPlus) who offer members a discount. These discounts range from 20%-50%, and are the best possible discounts available to Superior Vision.

[5] Discounts and maximums may vary by lens type. Please check with your provider.

*Higher end or brand name lens upgrades are at an additional expense. These upgrades will be available at a 20% discount off retail.

Items or Services Not Covered

While Superior Vision offers a variety of vision benefits, there are a few materials, services, and treatments that are generally not covered, or have limitations to their coverage. We do offer discounts on many of these items, as outlined in our discount plan coverage information. For a list of these, please see your benefits administrator. **Please confirm the details of your employer's plan prior to seeking services.**

Monthly Rates

Employee Only	$9.70
Employee + One	$18.80
Employee + Family	$27.60

Customer Service

800-507-3800
916-852-2277 Fax

Explanation of Benefits

Provider locator; provider nomination
Claims inquiries
Authorization numbers (out-of-network)
Grievance issues

Customer Service/Corporate Office

11101 White Rock Rd., Ste. 150
Rancho Cordova, CA 95670

Claims Administration

P.O. Box 967
Rancho Cordova, CA 95741

Disclaimer: All final determinations of benefits, administrative duties, and definitions are governed by the Certificate of Insurance Coverage for your vision plan. Please check with your Benefits Administrator or Human Resources department if you have any questions.

The Superior Vision Plan is underwritten by National Guardian Life Insurance Company. National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life

SUPERIOR VISION
See yourself healthy.

Aflac Group Accident Plan

Effective Date: July 1, 2016

Plan Description

Group accident insurance pays a benefit for the treatment of injuries suffered as the result of a covered accident. Benefits are paid regardless of any other health insurance benefits the insured may receive.

Why Offer Group Accident Insurance?

Most families don't budget for the costs associated with accidents. When an accident does occur the last thing on your mind are the charges accumulating while you or your loved one is at the emergency room:

- The ambulance ride
- Casts
- Use of the emergency room
- Wheelchairs
- Surgery and Anesthesia
- Crutches
- Stitches
- Bandages

These costs add up fast. Most families have medical insurance that will cover most of the expenses. But, what about the out-of-pocket medical expenses, such as an employee's or spouse's lost wages when he is out of work or staying home to care for an injured family member? You hope that an accident never happens, but at some point you will probably take a trip to your local emergency room. If that time comes, wouldn't it be nice to have an insurance plan that pays you a benefit regardless of any other insurance you have? Group accident insurance does just that, providing cash benefits to help with the costs associated with unexpected expenses that result from covered accidents.

Plan Features

- There's no limit on the number of claims an insured can file.
- The plan supplements and pays regardless of any other insurance programs.
- Benefits are available for spouse and/or dependent children.
- The coverage provides 24-hour (on and off-the-job) protection.
- Benefits are available for both inpatient **and** outpatient treatment of covered accidents.
- Coverage is guaranteed-issue which means no underwriting required in order for employees to qualify for coverage.
- Premiums are paid by convenient payroll deduction.

Individual Eligibility

Issue Ages

Employees 18-69
Spouse 18-64
Children under age 26, dependents

Full-time benefit eligible employees working at least 30 hours or more per week may apply for Aflac accident coverage. Seasonal and temporary employees are not eligible.

Spouse and Dependent Children Coverage Available

If the employee participates in the plan, then the employee's spouse and dependent children are eligible to participate. A *dependent child* is an employee's natural child, step-child, foster child, legally adopted child, or child placed for adoption. To be considered a dependent child, the child must be under age 26.

The employee must participate in order to purchase spouse and/or dependent child coverage.

With the exception of the specific benefits noted, the benefits for a covered spouse or dependent child are equal to the employee's benefit amounts.

Portability

When coverage is effective and would otherwise terminate under the plan because the employee ends employment with the employer, coverage may be continued. The employee can continue the coverage that is in force on the date employment ends, including dependent coverage then in effect.

The employee will be allowed to continue the coverage until the date he fails to pay the required premium or the date the group policy is terminated whichever is earlier.

Coverage may not be continued if:

- The employee fails to pay any required premium,
- The employee attains age 70, or
- The group policy terminates.

Termination

Insurance for an insured employee will terminate on the earliest of: (1) the date the master policy is terminated, (2) the 31st day after the premium due date if the premium has not been paid, (3) the date the employee ceases to meet the definition of an *employee* as defined in the master policy, (4) the premium due date that falls on or first follows the employee's 70th birthday, or (5) the date the employee is no longer a member of the class eligible.

Insurance for an insured spouse or dependent child will terminate the earliest of (1) he date the plan is terminated, (2) the date the spouse or dependent child ceases to be a dependent, (3) the premium due date following the date we receive the employee's written request to terminate coverage for his spouse and/or dependent children.

Effective Date

The effective date for an employee is as follows: (1) an employee's insurance will be effective on the date shown on the certificate schedule provided the employee is then actively at work. (2) If an employee is not actively at work on the date coverage would otherwise become effective, the effective date of his or her coverage will be the date on which such employee is first thereafter actively at work.

Accident Benefits

Complete Fractures (Diagnosis and treatment within 90 days)		
	Employee Closed Reduction	***Spouse/Child Closed Reduction***
Hip/Thigh	$4,500	$4,000
Vertebrae	$4,050	$3,600
Pelvis	$3,600	$3,200
Skull (Depressed)	$3,375	$3,000
Leg	$2,700	$2,400
Forearm/Hand	$2,250	$2,000
Foot/Ankle/Knee Cap	$ 2,250	$2,000
Shoulder Blade/Collar Bone	$1,800	$1,600
Lower Jaw (Mandible)	$1,800	$1,600
Skull (Simple)	$1,575	$1,400
Upper Arm/ Upper Jaw	$1,575	$1,400
Facial Bones (Except teeth)	$1,350	$1,200
Vertebral Processes	$900	$800
Coccyx/Rib/Finger/Toe	$360	$320

If the fracture requires open reduction, we will pay 150% the amount shown.
A fracture is a break in a bone that can be seen by X-ray. If a bone is fractured in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the appropriate amount shown.

Multiple fractures refer to more than one fracture requiring either open or closed reduction. If multiple fractures occur in any one covered accident, we will pay the appropriate amounts shown for each fracture. However, we will pay no more than 150% the benefit amount for the fractured bone which has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown for the affected bone.

The maximum amount payable for the Fracture Benefit per covered accident is 150% the benefit amount for the fractured bone that has the higher dollar amount.

Complete Dislocations (Diagnosis and treatment within 90 days)		
	Employee Closed Reduction	*Spouse/Child Closed Reduction*
Hip	$4,000	$3,000
Knee (not kneecap)	$2,600	$1,950
Shoulder	$2,000	$1,500
Foot/Ankle	$1,600	$1,200
Hand	$1,400	$1,050
Lower Jaw	$1,200	$900
Wrist	$1,000	$750
Elbow	$800	$600
Finger/Toe	$320	$240

If the dislocation requires open reduction, we will pay 150% of the amount shown.

Dislocation refers to a completely separated joint. If a joint is dislocated in a covered accident, and it is diagnosed and treated by a doctor within 90 days after the accident, we will pay the amount shown.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of the certificate and then dislocates the same joint again, it will not be covered by this plan.

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one covered accident. For each covered dislocation, we will pay the amounts shown. However, we will pay no more than 150% the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a doctor diagnoses and treats the accidental injury as a partial dislocation, we will pay 25% of the amount shown in the benefit schedule for the affected joint.

The maximum amount payable for the Dislocation Benefit per covered accident is 150% the benefit amount for the dislocated joint that has the higher dollar amount.

If you have **both** fracture and dislocation in the same covered accident, we will pay for both. However, we will pay no more than 150% the benefit amount for the fractured bone or dislocated joint that has the higher dollar amount.

Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000

Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown if, because of a covered accident:

- The insured is injured,
- The injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a doctor within 90 days after the accident.

The amount paid will be based on the number of limbs paralyzed.

If this benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate Death Benefit, less any amounts paid under the Paralysis Benefit.

Lacerations	
Up to 2" long	$50
2" - 6" long	$200
Over 6" long	$400
Lacerations not requiring stitches	$25

The laceration must be repaired with stitches by a doctor within 72 hours after the accident. The amount paid will be based on the length of the laceration.

If an insured suffers multiple lacerations in a covered accident, and the lacerations are repaired with stitches by a doctor within 72 hours after the accident, we will pay this benefit based on the largest single laceration which requires stitches.

Injuries Requiring Surgery	
Eye Injuries (treatment and surgery within 90 days)	$250
Removal of foreign body (requiring no surgery)	$50
Tendons/Ligaments (treatment within 60 days, surgical repair within 90 days) *Single* *Multiple* If the insured fractures a bone or dislocates a joint, and tears, severs, or ruptures a tendon or ligament in the same accident, we will pay one benefit. We will pay the largest of the scheduled benefit amounts for fractures, dislocations, or tendons and ligaments.	 $400 $600
Ruptured Disc (treatment within 60 days, surgical repair within one year) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400
Torn Knee Cartilage (within 60 days) *Injury occurs during first certificate year* *Injury occurs after first certificate year*	 $100 $400

Burns (treatment within 72 hours)	
First Degree	Not Covered
Second Degree *Less than 10% of body surface covered* *At least 10%, but not more than 25% of body surface covered* *At least 25%, but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $100 $200 $500 $1,000
Third Degree *Less than 10% of body surface covered* *At least 10%, but not more than 25% of body surface covered* *At least 25%, but not more than 35% of body surface covered* *More than 35% of body surface covered*	 $1,000 $3,000 $7,000 $10,000
Other Injuries	
Concussion (resulting in electroencephalogram abnormality)	$200
Coma (lasting 30 days or more) Coma means a state of profound unconsciousness caused by a covered accident.	$10,000
Internal Injuries (resulting in open abdominal or thoracic surgery)	$1,000
Exploratory Surgery (without repair, i.e. arthroscopy)	$250
Emergency Dental Work (sound natural teeth) *Repaired with crown* *Resulting in extraction*	 $150 $50

Medical Fees (for each accident)	
Employee or Spouse	$125
Child(ren)	$75

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room and
- Receives initial treatment within 72 hours after the covered accident.

This benefit is payable only once per 24-hour period and only once per covered accident.

We will not pay the Accident Emergency Room Treatment Benefit and the Medical Fees Benefit for the same covered accident. We will pay the highest eligible benefit amount.

Emergency Room Observation Benefit	
Employee or Spouse	$75
Child(ren)	$45

We will pay the amount shown for injuries received in a covered accident if the insured:

- Receives treatment in a hospital emergency room, and
- Is held in a hospital for observation for at least 24 hours, and
- Receives initial treatment within 72 hours after the accident.

This benefit is payable only once per 24-hour period and only once per covered accident. This benefit would be paid in addition to Accident Emergency Room Treatment Benefit.

Accident Follow-up Treatment - $25.00

We will pay the amount shown for up to six treatments per covered accident, per covered person. The insured must have received initial treatment within 72 hours of the accident, and the follow-up treatment must begin within 30 days of the covered accident or discharge from the hospital.

Physical Therapy - $25.00

We will pay this benefit for up to six treatments (one per day) per covered accident, per covered person for treatment from a physical therapist. A physician must prescribe the physical therapy. The insured must have received initial treatment within 72 hours of the accident and physical therapy must begin within 30 days of the covered accident or discharge from the hospital. Treatment must take place within six months after the accident. This benefit is not payable for the same visit that the accident follow-up treatment benefit is paid.

Air Ambulance - $500 Ambulance - $100

If an insured requires transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

Transportation (within 90 days)

- Train or Plane - $300
- Bus - $150

If hospital treatment or diagnostic study is recommended by your physician and is not available in your city of residence, we will pay the amount shown. The distance to the location of the hospital must be more than 50 miles from the insured's residence.

Blood/Plasma - $100

If the insured receives blood and plasma within 90 days following a covered accident, we will pay the amount shown.

Prosthesis - $500

If a covered accident requires the use of a prosthetic device, we will pay the amount shown. Hearing aids, wigs, or dental aids, including false teeth are not covered.

Appliance - $100

We will pay the amount shown for use of a medical appliance due to injuries received in a covered accident. Benefits are payable for crutches, wheelchairs, leg braces, back braces and walkers.

Family Lodging Benefit (per night) - $100

If an insured is required to travel more than 100 miles for inpatient treatment of injuries received in a covered accident, We will pay this benefit for an immediate family member's lodging. Benefits are payable up to 30 days per accident and only while the insured is confined to the hospital.

Wellness - $60

This benefit is payable while coverage is in force. This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. We will pay the amount shown once each 12-month period for each covered person for the following:

- Annual physical exams
- Blood screenings
- Mammograms
- Immunizations
- Pap smears
- PSA tests
- PSA tests
- Flexible Sigmoidoscopies
- Ultrasounds

Hospital Admission - $1,000

We will pay the amount shown, when because of a covered accident, the insured:

- Is injured,
- Requires hospital confinement, and
- Is confined to a hospital for at least 24 hours within 6 months after the accident date.

We will pay this benefit once per calendar year. We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Confinement (per day) - $200

We will provide this benefit on the first day of hospital confinement for up to 365 days. Hospital confinement must begin within 90 days from the date of the accident.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, and
- Those injuries cause confinement to a hospital for at least 24 hours within 90 days after the accident date.

The maximum period for which you can collect the Hospital Confinement Benefit for the same injury is 365 days.

This benefit is payable once per hospital confinement even if the confinement is caused by more than one accidental injury.

We will not pay this benefit for confinement to an observation unit. We will not pay this benefit for emergency room treatment or outpatient surgery or treatment.

Hospital Intensive Care (per day) - $400

We will pay the amount shown when, because of a covered accident, the insured:

- Is injured, and
- Those injuries cause confinement to a hospital intensive care unit.

The maximum period for which an insured can collect the Hospital Intensive Care Benefit for the same Injury is 30 days.

This benefit is payable in addition to the Hospital Confinement Benefit

Accidental Death & Dismemberment (within 90 days)			
	Employee	***Spouse***	***Children***
Accidental Death	$50,000	$10,000	$5,000
Accidental Common Carrier Death	$100,000	$50,000	$15,000
Single Dismemberment	$12,500	$5,000	$2,500
Double Dismemberment	$25,000	$10,000	$5,000
Loss of One or More Fingers and Toes	$1,250	$500	$250
Partial Amputation of Finger(s) or Toe(s) (including at least one joint)	$100	$100	$100

Dismemberment means:

1. Loss of a hand: the hand is cut off at or above the wrist joint; or
2. Loss of a foot: the foot is cut off at or above the ankle; or
3. Loss of sight: at least 80% of the vision in one eye is lost. Such loss of sight must be permanent and irrecoverable or
4. Loss of a finger/toe: the finger or toe is cut off at or above the joint where it is attached to the hand or foot.

If the employee does not qualify for the dismemberment benefit but loses at least one joint of a finger or toe, we will pay the partial dismemberment shown. If this benefit is paid and the employee later dies as a result of the same covered accident, we will pay the appropriate death benefit, less any amounts paid under this benefit.

Accidental Death

If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Death Benefit shown.

Accidental Common Carrier Death

If the employee is injured in a covered accident and the injury causes him/her to die within 90 days after the accident, we will pay the Accidental Common Carrier Death Benefit in the amount shown if the injury is the result of traveling as a fare paying passenger on a common carrier, as defined below. This benefit is paid in addition to the Accidental Death Benefit.

Common carrier means:

- an airline carrier which is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports; or
- a railroad train which is licensed and operated for passenger service only; or
- a boat or ship which is licensed for passenger service and operated on a regular schedule between established ports.

Limitations and Exclusions

We will not pay benefits for injury, total disability, or death contributed to, caused by, or resulting from:

- Participating in war or any act of war, declared or not, or participating in the armed forces of or contracting with any country or international authority. We will return the prorated premium for any period not covered when you are in such service.
- Operating, learning to operate, serving as a crew member on, or jumping or falling from any aircraft, including those that are not motor-driven.
- Participating or attempting to participate in an illegal activity or working at an illegal job.
- Committing or attempting to commit suicide, while sane or insane.
- Injuring or attempting to injure yourself intentionally.
- Having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for such illness.
- Traveling more than 40 miles outside the territorial limits of the United States, Canada, Mexico, Puerto Rico, the Bahamas, the Virgin Islands, Bermuda, and Jamaica, except under the Accidental Common-Carrier Death Benefit.
- Riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.
- Participating in any professional or semiprofessional organized sport.
- Being legally intoxicated or under the influence of any narcotic, unless taken under the direction of a physician.
- Mountaineering using ropes and/or other equipment, parachuting, or hang gliding.
- Having cosmetic surgery or other elective procedures that are not medically necessary, or having dental treatment, except as a result of a covered accident.

A doctor or physician does not include you or a member of your immediate family.
A hospital is not a nursing home, an extended-care facility, a convalescent home, a rest home or a home for the aged, a place for alcoholics or drug addicts, or a mental institution.

Pre-Existing Condition Limitation

We will not pay benefits for a loss that is caused by, that is contributed to, or that results from a pre-existing condition for 12 months after the effective date of coverage. Pre-Existing Condition means within the 12-month period prior to the effective date of this certificate and attached riders, as applicable. A claim for benefits for loss starting after 12 months from the effective date of a certificate and attached riders will not be reduced or denied on the grounds that it is caused by a pre-existing condition.
A certificate may have been issued as a replacement for a certificate previously issued under the plan. If so, then the pre-existing condition limitation provision of the certificate applies only to any increase in benefits over the prior certificate. Any remaining period of the pre-existing condition limitation of the prior certificate will continue to apply to the prior level of benefits.

What would my payroll deduction cost be for the Aflac accident plan?

Monthly Premium Rates

Employee	$16.20
Employee and Spouse	$23.16
Employee and Dependent Child(ren)	$30.90
Employee, Spouse, and Dependent Child(ren)	$37.86

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

Continental American Insurance Company
Columbia, South Carolina

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned. This means that you may not receive any of the benefits in the plan. As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

Customer Service
800.433.3036 / Aflacgroupinsurance.com

Aflac®

We've got you under our wing.®

Allstate Benefits Group Cancer Plan

Effective Date: July 1, 2016

In the United States, about 1,665,540 new cancer cases were expected to be diagnosed in 2014. [1]

Group Voluntary Cancer

If you suddenly become diagnosed with cancer, it can be difficult on your family's financial and emotional stability. Having the right coverage to help when you are sick and undergoing treatment or when you cannot work is important. Our cancer insurance can help provide security when you need it most.

Meeting Your Needs:

Our cancer coverage can help offer you and your family member financial support during a period of unexpected illness.

- Benefits will be paid directly to you unless otherwise assigned
- Coverage can be purchased for you and your entire family
- Waiver of premium after 90 days of disability due to cancer for as long as your disability due to cancer lasts*
- Includes coverage for 29 other specified diseases**
- Portable coverage

Benefit Coverage Highlights

Group Voluntary Cancer Insurance offer you coverage should you be diagnosed with cancer or 29 specified diseases. It can help protect you and your family 24 hours a day, seven days a week. Each pre-packaged plan doesn't just cover you; if you choose, it also covers your dependents (which can include spouse and dependent children.) This valuable coverage can help supplement your traditional medical insurance which may only cover a small portion of the non-medical expenses that can be incurred with such a diagnosis as cancer.

You and each covered family member can be sure they will receive:

- Benefits that help pay for treatment, hospital stays, transportation, and much more!
- Easy enrollment without required evidence of insurability.†

A cancer diagnosis can mean unforeseen expenses that may be difficult to pay, especially if you aren't working. Hospital stays, medical or surgical treatments, and transportation by air or ground ambulance can add up quickly and be very costly. Group Voluntary Cancer Supplemental Insurance helps offset some of the expenses your health insurance may not cover, so you can focus on getting well.

**Primary insured only*

***List of covered disease on the next page*

[1] Cancer Facts & Figures, American Cancer Society, 2014

† Enrolling after your initial enrollment period requires evidence of insurability

In the U.S., men have slightly less than a 1 in 2 lifetime risk of developing cancer, for women, the risk is a little more than 1 in 3.[2]

Your Benefit Coverage

Benefits are paid for cancer and specified disease and can help cover the costs of specific treatments and expenses as they happen. Terms and conditions for each benefit will vary.

Specified Diseases

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis (bacterial), Brucellosis, Sickle Cell Anemia, Thallasemia, Rocky Mountain Spotted Fever, Legionnaire's Disease (confirmation by culture or sputum), Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or Chronic C with liver failure or Hepatoma), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Liver Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis.

Continuous Hospital Confinement

A $100 benefit will be paid for each day of continuous hospital confinement for the treatment of cancer or specified diseases.

Government or Charity Hospital

A $100 benefit will be paid for each day a covered person is confined to: 1. a hospital operated by or for the U.S. Government (including the Veteran's Administration); or 2. a hospital that does not charge for the services it provides (charity). This benefit is paid in lieu of all other benefits in the policy (except Waiver of Premium Benefit).

Surgery

Up to a $3,000 benefit will be paid** when a covered surgery (**amount per surgery depends on surgery) is performed on a covered person. This benefit pays the actual charges, up to the amount listed in the Schedule of Surgical Procedures for the specific procedure. Two or more procedures performed at the same time through one incision or entry point are considered one operation; Allstate Benefits pays the amount for the procedure with the greatest benefit. Allstate Benefits pays for a covered surgery performed on an outpatient basis at 150% of the scheduled benefit. This benefit does not pay for surgeries covered by other benefits in the Schedule of Benefits.

Second Opinion

A $400 benefit will be paid for a second surgical opinion, if physician recommends surgery for covered condition. This second opinion must be rendered prior to surgery or treatment being performed, and obtained from a physician not in practice with the physician rendering the original recommendation.

[2] Cancer Facts & Figures, American Cancer Society, 2014

Physical or Speech Therapy

A $50 benefit will be paid per day, for physical or speech therapy for restoration of normal body function.

Anesthesia

25% of the surgery benefit will be paid for anesthesia.

Ambulatory Surgical Center

A $500 benefit will be paid for a surgical procedure covered under the Surgery benefit that is performed at an ambulatory surgical center.

Radiation/Chemotherapy for Cancer

Up to a $10,000 benefit will be paid per 12 month period for radiation therapy and chemotherapy received by a covered person. This benefit pays the actual cost and is limited to the amount shown per 12 month period beginning with the first day of benefit under this provision. Administration of radiation therapy or chemotherapy other than by medical personnel in a physician's office or hospital, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period.

Anti-Nausea Benefit

Up to a $200 benefit will be paid per calendar year for the actual cost of anti-nausea medication prescribed for a covered person by a physician in conjunction with cancer or specified disease treatment. This benefit does not pay for medication administered while the covered person is an inpatient.

Inpatient Drugs and Medicine

A $25 benefit will be paid per day for drugs and medicine while continuously hospital confined. This benefit does not pay for drugs and/or medicine covered under the Radiation/Chemotherapy Benefit or the Anti-Nausea Benefit.

Hematological Drugs

Up to a $200 benefit will be paid per year for the actual cost of drugs intended to boost cell lines such as white blood cell counts, red blood cell counts and platelets. This benefit is paid only when the Radiation/Chemotherapy for Cancer benefit is paid.

Medical Imaging

Actual cost up to a $500 benefit will be paid per calendar year if a covered person receives an initial diagnosis or follow-up evaluation based upon one of the following medical imaging exams: CT scan; Magnetic Resonance Imaging (MRI) scan; bone scan; thyroid scan; Multiple Gated Acquisition (MUGA) scan; Positron Emission Tomography (PET) scan; transrectal ultrasound; or abdominal ultrasound. This benefit is limited to 1 payment per calendar year per covered person.

Private Duty Nursing Services

A $100 benefit will be paid per day while hospital confined, if a covered person requires the full-time services of a private nurse. Full-time means at least 8 hours of attendance during a 24 hour period. These services must be required and authorized by a physician and must be provided by a nurse.

New or Experimental Treatment

Actual charges up to a $5,000 benefit will be paid per 12 month period, for new or experimental treatment. New or Experimental Treatment is covered for cancer and specified disease when: the treatment is judged necessary by the attending physician; and no other generally accepted treatment produces superior results in the opinion of the attending physician. This benefit is limited to the maximum shown per 12 month period beginning with the first day of treatment under this provision. This benefit does not pay if benefits are payable for treatment covered under any other benefit in the Schedule of Benefits.

Blood, Plasma, and Platelets

Up to a $10,000 benefit will be paid per 12 month period, for the actual cost of blood, plasma and platelets (including transfusions and administration charges); processing and procurement costs; and cross-matching. Does not pay for blood replaced by donors or immunoglobulins.

Physician's Attendance

A $50 benefit will be paid for a visit by a physician during hospital confinement. Benefit is limited to one visit by one physician per day of hospital confinement. Admission to the hospital as an inpatient is required.

At Home Nursing

A $100 benefit will be paid per day for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the attending physician. Benefit is limited to the number of days of the previous continuous hospital confinement.

Prosthesis

Up to a $2,000 benefit will be paid per amputation, per covered person for the actual charges for prosthetic devices which are prescribed as a direct result of surgery and which require surgical implantation.

Hair Prosthesis

A $25 benefit will be paid every 2 years, for a wig or hairpiece if the covered person experiences hair loss.

Nonsurgical External Breast Prosthesis

Up to a $50 benefit will be paid for the actual cost of the initial, nonsurgical breast prosthesis following a covered mastectomy or partial mastectomy that is paid for under the policy.

Ambulance

A $100 benefit will be paid per continuous hospital confinement for transportation by a licensed ambulance service or a hospital owned ambulance to or from a hospital in which the covered person is confined.

Hospice Care

A $100 benefit will be paid for one of the following when a covered person has been diagnosed by a physician as terminally ill as a result of cancer or specified disease, is expected to live 6 months or less and the attending physician has approved services: (1) Freestanding Hospice Care Center – A benefit will be paid per day for confinement in a licensed freestanding hospice care center. Benefits payable for hospice centers that are designated areas of hospitals will be paid the same as inpatient hospital confinement; or (2) Hospice Care Team – A benefit will be paid per visit, limited to 1 visit per day, for home care services by a hospice care team. Home care services are hospice services provided in the patient's home. Benefit is payable only if: (a) the covered person has been diagnosed as terminally ill; and (b) the attending physician has approved such services. Does not pay for: food services or meals other than dietary counseling; or services related to well-baby care; or services provided by volunteers; or support for the family after the death of the covered person.

Extended Care Facility

A $100 benefit will be paid for each day a covered person is confined in an extended care facility for the treatment of cancer or specified disease. Confinement must be at the direction of the attending physician and must begin within 14 days after a covered hospital confinement. Benefit is limited to the number of days of the previous continuous hospital confinement.

Outpatient Lodging

A $50 benefit will be paid for lodging per day when a covered person receives radiation or chemotherapy treatment on an outpatient basis, provided the specific treatment is authorized by the attending physician and cannot be obtained locally. Benefit is the actual cost of a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits during treatment, **up to the maximum $2,000** per 12 months beginning with the first day of benefit under this provision. Outpatient treatment must be received at a treatment facility more than 100 miles from the covered person's home.

Non-Local Transportation

$0.40 per mile or actual cost of round trip coach fare on a common carrier benefit will be paid for treatment at a hospital (inpatient or outpatient); or radiation therapy center; or chemotherapy or oncology clinic; or any other specialized freestanding treatment center nearest to the covered person's home, provided the same or similar treatment cannot be obtained locally. Benefit pays up to 700 miles for round trip in personal vehicle. "Non-Local" means a round trip of more than 70 miles from the covered person's home to the nearest treatment facility. Mileage is measured from the covered person's home to the nearest treatment facility as described above. Does not cover transportation for someone to accompany or visit the person receiving treatment; visits to a physician's office or clinic; or for services other than actual treatment.

Family Member Lodging and Transportation

Up to a $50 benefit per day will be paid for lodging and $0.40 per mile or the actual cost of round trip coach fare on a common carrier will be paid for one adult member of the covered person's family to be near the covered person, when a covered person is confined in a non-local hospital for specialized treatment. 1. Lodging - This benefit is for a single room in a motel, hotel, or other accommodations acceptable to Allstate Benefits. Benefit is limited to 60 days for each period of continuous hospital confinement. 2. Transportation - Benefit is limited to 700 miles per continuous hospital confinement if traveling in personal vehicle. Mileage is measured from the visiting family member's home to the hospital where the covered person is confined. Does not pay the Family Member Transportation Benefit if the personal vehicle transportation benefit is paid under the Non-Local Transportation Benefit, when the family member lives in the same city or town as the covered person.

Waiver of Premium (primary insured only)

If while coverage is in force the insured employee becomes disabled due to cancer first diagnosed after the effective date of coverage and remains disabled for 90 days, Allstate Benefits pays premiums due after such 90 days for as long as the insured employee remains disabled.

*Bone Marrow or Stem Cell Transplant**

A (1) $1,000*, (2) $2,500*, (3) $5,000* benefit will be paid for the following types of bone marrow or stem cell transplants performed on a covered person. (1) A transplant which is other than non-autologous. (2) A transplant which is non-autologous for the treatment of cancer or specified disease, other than Leukemia. (3) A transplant which is non-autologous for the treatment of Leukemia. ***This benefit is payable only once per covered person per calendar year.**

Additional Benefits

Wellness

A $100 benefit will be paid per calendar year per covered person for one of the following wellness tests: Biopsy for skin cancer; Blood test for triglycerides; Bone Marrow Testing; CA15-3 (cancer antigen 15 - 3 - blood test for breast cancer); CA125 (cancer antigen 125 – blood test for ovarian cancer); CEA (carcinoembryonic antigen – blood test for colon cancer); Chest X-ray; Colonoscopy; Doppler screening for carotids; Doppler screening for peripheral vascular disease; Echocardiogram; EKG (Electrocardiogram); Flexible sigmoidoscopy; Hemocult stool analysis; HPV (Human Papillomavirus) Vaccination; Lipid panel (total cholesterol count); Mammography, including Breast Ultrasound; Cervical Cancer Screening; PSA (prostate specific antigen – blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); Stress test on bike or treadmill; Thermography; and Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms. This benefit is paid regardless of the result of the test.

Optional Benefits

Cancer Initial Diagnosis (First Occurrence)

A one time benefit of $3,000 benefit will be paid when a covered person is diagnosed for the first time in their life as having cancer other than skin cancer. The first diagnosis must occur after the effective date of coverage for that covered person. Benefit is payable only once per covered person.

*Intensive Care***

A benefit will be paid for each day for the following types of intensive care confinement:

A. Hospital Intensive Care Unit Confinement $600* - This benefit is for hospital intensive care unit confinement for any illness or accident.

B. Step-Down Hospital Intensive Care Unit Confinement $300*- This benefit is for step down hospital intensive care unit confinement for any illness or accident.

C. Ambulance - Allstate Benefits pays the actual charges for transportation of a covered person by licensed air or surface ambulance service to a hospital for admission to an intensive care unit for a covered confinement. This benefit is not paid if an ambulance benefit is paid under the Ambulance benefit in the policy.

****This benefit is limited to 45 days for each period of such confinement. A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid.**

Eligibility

Family members eligible for coverage include: you; your legal spouse or domestic partner; and your children.

Portability Privilege

Allstate Benefits will provide portability coverage, subject to these provisions. Such coverage will not be available for you, unless: coverage under the policy terminates under the General Provision entitled "Termination of Coverage"; and we receive a written request and payment of the first premiums for the portability coverage not later than 30 days after such termination; and the request is made for that purpose. No portability coverage will be provided to you, if your insurance under the policy terminated due to your failure to make required premium payments.

Termination of Coverage

As long as you are insured, your coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which you made any required premium payments; or the last day you are in active employment except as provided under the "Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible. Allstate Benefits will provide coverage for a payable claim incurred while you are covered under the policy. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. If your domestic partner is a covered person, the domestic partner's coverage ends upon termination of the domestic partnership or your death. If your child is a covered person, the child's coverage ends when the child reaches age 26, unless he or she continues to meet the requirements of an eligible dependent. Coverage does not terminate on a child who: (1) is incapable of self-sustaining employment by reason of mental or physical incapacity; and (2) became so incapacitated prior to the attainment of the limiting age of eligibility under the coverage; and (3) is chiefly dependent upon you for support and maintenance. Dependent coverage continues as long as the coverage remains in force and the dependent remains in such condition. Proof of the incapacity and dependency of the child must be furnished within 60 days of the child's attainment of the limiting age of eligibility. Thereafter, such proof must be furnished as frequently as may be required, but no more frequently than annually after the child's attainment of the limiting age for eligibility. If Allstate Benefits accepts a premium for coverage extending beyond the date, age or event specified for termination as to a covered person, such premium will be refunded, coverage will terminate and claims will not be paid.

Pre-Existing Condition, Exclusions and Limitations

Allstate Benefits does not pay for any benefit due to, or caused by, a pre-existing condition, as defined, during the 12 month period beginning on the date that person became a covered person. This exclusion will not apply to your newborn, adopted or foster child under the age of 18 if Allstate Benefits is notified within 31 days of the child's birth or date of placement. A Pre-Existing Condition is a disease or condition for which medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date.

Allstate Benefits does not pay for any loss except for losses due directly from cancer or specified disease. Allstate Benefits does not pay for any other conditions or diseases caused or aggravated by cancer or a specified disease. Diagnosis must be submitted to support each claim. For the Surgery, New or Experimental Treatment and Prosthesis Benefits, if specific charges are not obtainable as proof of loss, Allstate Benefits will pay 50% of the applicable maximum for the benefits payable. Treatment must be received in the United States or its territories.

Intensive Care Exclusions and Limitations

The Hospital Intensive Care Unit Confinement benefit does not pay for intensive care if a covered person is admitted because of an attempted suicide; or intentional self-inflicted injury; or intoxication; or being under the influence of drugs not prescribed or recommended by a physician; or alcoholism or drug addiction. Allstate Benefits does not pay for confinements in any care unit that does not qualify as a hospital intensive care unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as hospital intensive care units. Allstate Benefits does not pay for step down hospital intensive care unit confinement if a covered person is admitted and confined in the following type of units: telemetry or surgical recovery rooms; post-anesthesia care units, progressive care units; intermediate care units; private monitored rooms; observation units located in emergency rooms or outpatient surgery units; beds, wards, or private or semi-private rooms with or without telemetry monitoring equipment; an emergency room; labor or delivery rooms; or other facilities that do not meet the standards for a step-down hospital intensive care unit. Allstate Benefits does not pay this benefit for continuous hospital intensive care unit confinements or continuous step-down hospital intensive care unit confinements that occur during a hospitalization that begins before the effective date of coverage. We do not pay for ambulance if paid under the cancer and specified disease ambulance benefit.

Coverage Subject to the Policy

The coverage described in the certificate of insurance is subject in every way to the terms of the policy that is issued to the policyholder (your employer). It alone makes up the agreement by which the insurance is provided. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. Your consent is not required for this. Allstate Benefits is not required to give you prior notice.

The policy is Limited Benefit Cancer and Specified Disease Insurance.

This is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide available from American Heritage Life Insurance Company. Subject to COBRA continuation of coverage.

The coverage is provided by a limited benefit supplemental insurance policy.

This coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. This material is valid as long as information remains current, but in no event later than October 1, 2018. Group Cancer and Specified Disease benefits provided by policy GVCP3, or state variations thereof. The policy and rider are underwritten by American Heritage Life Insurance Company. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificate issued.

This brochure is for use in enrollments which are sitused in North Carolina.

Allstate Benefits is the marketing name used by
American Heritage Life Insurance Company
(Home Office, Jacksonville, FL),
a subsidiary of The Allstate Corporation.

Allstate Benefits, The Workplace Marketer ©
1776 American Heritage Life Drive, Jacksonville, Florida 32224

Customer Care Center: 800-521-3535
www.allstate.com or AllstateBenefits.com

Monthly Rates

Issue Ages: 18 and older while actively at work.

Certificates - Certificates under this plan are issued on a guaranteed basis only at the time of the initial enrollment. A completed Evidence of Insurability form is required for late entrants into the group plan.

Option without Cancer Initial Diagnosis and Intensive Care

Insureds	*Monthly*
Employee	$20.07
Employee + Child(ren)	$27.71
Employee + Spouse	$30.96
Family	$38.57

Option with Cancer Initial Diagnosis and Intensive Care

Insureds	*Monthly*
Employee	$26.06
Employee + Child(ren)	$36.81
Employee + Spouse	$41.50
Family	$52.23

Aflac Group Critical Illness Plan

Effective Date: July 1 2016

Benefit Amounts Available:

- Employee: $5,000, $10,000, $15,000, $20,000, $25,000, $30,000, $35,000, $40,000, $45,000, $50,000
- Spouse: $5,000, $7,500, $10,000, $12,500, $15,000, $17,500, $20,000, $22,500, $25,000, $30,000

Guaranteed Issue Amounts:

- Employee: $20,000
- Spouse: $10,000

Health Screening Benefit: $100.00

The Aflac coverage described in this booklet is subject to plan limitations, exclusions, definitions, and provisions. For detailed information, please see the plan brochure, as this booklet is intended to provide a general summary of the coverage. This overview is subject to the terms, conditions, and limitations.

What is Aflac critical illness insurance? Why should I consider it?

Aflac critical illness insurance provides lump sum benefits upon the diagnosis of each covered critical illness or event, including the following:

- Major Organ Transplant
- End-Stage Renal Failure
- Stroke
- Coma
- Paralysis
- Burns
- Loss of Sight
- Loss of Hearing
- Loss of Speech
- Heart Attack
- Coronary Artery Bypass Surgery
- Specific Heart Procedures

Any of these diagnoses or events would be life-changing. While major medical insurance can help with the costs of treatment, ***what about the out-of-pocket expenses that pile up*** while you or a loved one is out of work as a result of a covered critical illness? Aflac critical illness insurance ***benefits are paid directly to you (unless otherwise assigned) to use as you see fit.*** You can use the benefits to help with groceries, car payments, mortgage or rent payments—however you like.

What are some of the highlights of the Aflac critical illness plan?

- An annual Health Screening Benefit is included.
- Spouse coverage is available.
- Benefit amounts range from $5,000 to $50,000 for employees. The benefit amount for spouses is $5,000 to $30,000.
- Each dependent child is covered at 50% of the primary insured's amount at no additional charge.
- Coverage may be guaranteed-issue (which means you may qualify for coverage without having to answer health questions).

- Your premiums are paid through the convenience of payroll deduction.
- Your plan is portable (with certain stipulations). That means you may be able to take your coverage with you if you leave your job.

Am I eligible for Aflac critical illness coverage? What about my family?

You are eligible to apply for Aflac critical illness coverage if you:

- Are between the ages of 18 and 69;
- Are a full-time, benefit-eligible employee;
- Are working at least 30 hours per week; **and**
- Are not a seasonal or temporary employee.

Your spouse must be between the ages of 18 and 69 to be eligible for coverage, and dependent children must be younger than age 26.

What core benefits does the Aflac critical illness plan feature?

First Occurrence Benefit

After the waiting period, you may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit

After the waiting period, you may receive benefits for each different covered critical illness. Dates of diagnosis must be separated by at least six months.

Reoccurrence Benefit

You may receive benefits for the recurrence of any covered critical illness. Dates of diagnosis must be separated by at least 12 months.

Heart Event Rider

After the waiting period, you may receive benefits for the following covered heart surgeries and procedures:

- Coronary Artery Bypass Surgery (reduces the benefit for heart attack)
- Mitral valve replacement or repair
- Aortic valve replacement or repair
- Surgical treatment of abdominal aortic aneurysm
- AnjioJet clot busting*
- Balloon angioplasty (or balloon valvuloplasty)*
- Laser angioplasty*
- Atherectomy*
- Stent implantation*
- Cardiac catherization*
- Automatic implantable (or internal) cardioverter defibrillator (AICD)*
- Pacemaker insertion*

**Benefits for these procedures are payable at a percentage of your maximum benefit and will reduce the benefit amounts payable for other covered heart procedures.*

Health Screening Benefit

After the waiting period, you may receive a maximum of $100 for any one covered screening test per calendar year (regardless of the test results). This benefit is payable for you (the employee) and your covered spouse, not for dependent children. Covered screening tests include the following:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermograph

What else do I need to know about the Aflac critical illness plan?

You should know that the plan includes:

- A **30-day waiting period.** This means that no benefits are payable for any insured before coverage has been in force 30 days from your effective date of coverage.
- Pre-Existing Condition means a sickness or physical condition which, within the 12-month period prior to the effective date, resulted in you receiving medical advice or treatment.
- We will not pay benefits for any critical illness starting within 12 months of the effective date which i is caused by, contributed to, or resulting from a pre-existing condition. A claim for benefits for loss starting after 12 months from the effective date will not be reduced or denied on the grounds that it is caused by a pre-existing condition. A critical illness will no longer be considered pre-existing at the end of 12 consecutive months starting and ending after the effective date.

Certain reductions.

No benefits are payable for loss resulting from:

- Intentionally self-inflicted injury or action;
- Suicide or attempted suicide while sane or insane;
- Illegal activities or participation in an illegal occupation;
- War, whether declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence;
- Substance abuse; **or**
- Diagnosis and/or treatment received outside the United States.
- Pre-Existing Conditions (except as stated above)
- No benefits will be paid for loss which occurred prior to the effective date.

Note: If this coverage will replace any existing individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.

This is a brief product overview only. The plan has limitations and exclusions that may affect benefits payable. Refer to the plan for complete details, limitations, and exclusions.

Continental American Insurance Company
Columbia, South Carolina

Continental American Insurance Company is not aware of whether you receive benefits from Medicare, Medicaid, or a state variation. If you or a dependent are subject to Medicare, Medicaid, or a state variation, any and all benefits under this plan could be assigned.

This means that you may not receive any of the benefits in the plan.

As a result, please check to the coverage in all health insurance policies you already have or may have before you buy this insurance to verify the absence of any assignments or liens.

800.433.3036 | aflacgroupinsurance.com

Underwritten by Continental American Insurance Company

A proud member of the Aflac family of insurers

Aflac®

We've got you under our wing.®

Monthly Rates for Employee and Spouse

NON-TOBACCO - Employee

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.52	$7.54	$9.56	$11.57	$13.59	$15.61	$17.63	$19.65	$21.67	$23.69
30-39	$6.89	$10.27	$13.66	$17.04	$20.43	$23.82	$27.20	$30.59	$33.97	$37.36
40-49	$10.44	$17.38	$24.32	$31.26	$38.20	$45.14	$52.08	$59.02	$65.96	$72.90
50-59	$15.20	$26.89	$38.59	$50.28	$61.98	$73.67	$83.37	$97.06	$108.76	$120.45
60-69	$25.34	$47.18	$69.02	$90.86	$112.71	$134.55	$156.39	$178.23	$200.07	$221.91

NON-TOBACCO - Spouse

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000	$30,000
18-29	$5.52	$6.53	$7.54	$8.55	$9.56	$10.57	$11.57	$12.58	$13.59	$15.61
30-39	$6.89	$8.58	$10.27	$11.96	$13.66	$15.35	$17.04	$18.74	$20.43	$23.82
40-49	$10.44	$13.91	$17.38	$20.85	$24.32	$27.79	$31.26	$34.73	$38.20	$45.14
50-59	$15.20	$21.04	$26.89	$32.74	$38.59	$44.43	$50.28	$56.13	$61.98	$73.67
60-69	$25.34	$36.26	$47.18	$58.10	$69.02	$79.94	$90.86	$101.79	$112.71	$134.55

TOBACCO - Employee

	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$6.61	$9.72	$12.83	$15.94	$19.04	$22.15	$25.26	$28.37	$31.48	$34.59
30-39	$8.85	$14.20	$19.55	$24.90	$30.24	$35.59	$40.94	$46.29	$51.64	$56.99
40-49	$17.21	$30.92	$44.63	$58.34	$75.05	$85.76	$99.47	$113.18	$126.88	$140.59
50-59	$26.68	$49.86	$73.04	$96.22	$119.41	$142.59	$165.77	$188.95	$212.13	$235.31
60-69	$45.28	$87.06	$128.85	$170.63	$212.41	$254.19	$295.98	$337.76	$379.54	$421.32

TOBACCO - Spouse

	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000	$30,000
18-29	$6.61	$8.16	$9.72	$11.27	$12.83	$14.38	$15.94	$17.49	$19.04	$22.15
30-39	$8.85	$11.52	$14.20	$16.87	$19.55	$22.22	$24.90	$27.57	$30.24	$35.59
40-49	$17.21	$24.06	$30.92	$37.77	$44.63	$51.48	$58.34	$65.19	$75.05	$85.76
50-59	$26.68	$38.27	$49.86	$61.45	$73.04	$84.63	$96.22	$107.82	$119.41	$142.59
60-69	$45.28	$66.17	$87.06	$107.96	$128.85	$149.74	$170.63	$191.52	$212.41	$254.19

AUL Short Term Disability

Effective Date: July 1, 2016

Why should you consider purchasing disability insurance protection at your workplace?

Many of us lead busy lives and seldom take time to think about life's risks. Consider the following reasons many people purchase disability insurance:

- Lost wages
- Daily living expenses, such as mortgage/rent, utilities, car payment, food, childcare, eldercare, hobbies, pet care

Advantages of shopping at work include:

- Affordable group rates
- Convenient payroll deduction
- Guaranteed issue for timely applicants
- Easy access

Less than 5% of disabling accidents and illnesses are work related.
The other 95% are not, meaning Workers' Compensation doesn't cover them.

(Source: Council for Disability Awareness, Long-Term Disability Claims Review, 2011. http://www.disabilitycan happen.org/research/CDA_LTD_ Claims_Survey_2011.asp

90% of disabilities are caused by illness.

(Source: Council for Disability Awareness, http://www.disability-canhappen.org/chances_disability_stats.asp., August 2012.)

64% of wage earners believe they have a 2% or less chance of being disabled for 3 months or more during their working career.
The actual odds for a worker entering the workforce today are about 30%.

(Source: Social Security Administration website, ssa.gov, Fact Sheet, March 18, 2011.)

Less than half (35.6%) of the 2.9 million workers who applied for Social Security Disability Insurance (SSDI) benefits in 2011 were approved.

(Source: Social Security Administration website, ssa.gov, Monthly Statistical Snapshot, December 2012.)

Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Short Term Disability Insurance

Disability

You are considered disabled if, because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation, you are not working in any occupation, and are under the regular attendance of a Physician for that injury or sickness.

Monthly Benefit

You can choose to insure up to 70% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000.

Elimination Period

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; seven (7) consecutive days for a sickness and zero (0) days for injury.

Basis of Coverage

24 hour coverage, on or off the job.

Maternity Coverage

Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

STD Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Recurrent Disability

If you resume Active Work for 30 consecutive workdays following a period of Disability for which the Weekly Benefit was paid, any recurrent Disability will be considered a new period of Disability. A new Elimination Period must be completed before the Weekly Benefit is payable.

Exclusions and Limitations

This plan will not cover any disability resulting from war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period.

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 to $1000 monthly benefit without medical questions, subject to the pre-existing exclusion. Current participants may increase their coverage up to $500 monthly benefit without medical questions. The maximum benefit cannot exceed 70% of basic monthly earnings and must be in $100 increments.

Portability

Once an employee is on the AUL disability plan for 3 consecutive months, you may be eligible to port your coverage for one year at the same rate without evidence of insurability. You have 31 days from your date of termination to submit an application to port your coverage.

The Portability Privilege is not available to any person that retires (when the Person receives payment from any Employer's Retirement Plan as recognition of past services or has concluded his/her working career).

Please refer to the Mark III website for a copy of your certificate, a claim form or application to port form.

This information is provided as a summary of the product. It is not a part of the insurance contract and does not change or extend AUL's liability under the group policy. If there are any discrepancies between this information and the group policy, the group policy will prevail.

Customer Service:
800-553-5318

Disability Claims:
866-258-8744
Fax: 207-766-3448

Disability Claims E-mail: claims@disabilityrms.com

www.employeebenefits.aul.com

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AUL Life Short-Term Disability
Monthly Rates

Benefit Duration:
13 weeks

Monthly Benefit	*Monthly Premium*
$500	$10.36
$600	$12.43
$700	$14.50
$800	$16.57
$900	$18.64
$1,000	$20.71
$1,100	$22.78
$1,200	$24.85
$1,300	$26.92
$1,400	$28.99
$1,500	$31.07
$1,600	$33.14
$1,700	$35.21
$1,800	$37.28
$1,900	$39.35
$2,000	$41.42

AUL Voluntary Long-Term Disability

Effective Date: July 1, 2016

Class Description

All Full-Time Eligible Employees working a minimum of 30 hours per week, electing to participate in the Voluntary Long Term Disability.

Monthly Benefit

You can choose to insure up to 60% of an Employee's covered basic monthly earnings to a maximum monthly benefit of $2,000 in $500 increments. The minimum benefit is $500.

Elimination Period

This means a period of time a disabled Employee must be out of work and totally disabled before weekly benefits begin; 90 consecutive days for a sickness or injury.

Benefit Duration

This is the period of time that benefits will be payable for long term disability. Up to 5 years if disabled prior to age 61, or if disabled after age 61, as outlined below:

Age When Total Disability Begins	Maximum Period Benefits are Payable
Prior to Age 61	5 Years
61	Lesser of SSFRA or 5 Years
62	3.5 Years
63	3 Years
64	2.5 Years
65	2 Years
66	21 Months
67	18 Months
68	15 Months
Age 69 and Over	12 Months

Disability Definition

An Insured is considered Totally Disabled, if, because of an injury or sickness, he cannot perform the material and substantial duties of his Regular Occupation, is not working in any occupation and is under the regular care of physician. After benefits have been paid for 24 months, the definition of disability changes to mean the Insured cannot perform the material and substantial duties of any Gainful Occupation for which he is reasonably fitted for by training, education or experience.

Mental & Nervous / Drug & Alcohol

Benefit payments will be limited to benefit duration or 24 months, whichever is less, cumulative for each of these limitations for treatment received on an outpatient basis. Benefit payments may be extended if the treatment for the disability is received while hospitalized or institutionalized in a facility licensed to provide care and treatment for the disability.

Special Conditions

Benefits for Disability due to Special Conditions, whether or not benefits were sought because of the condition, will not be payable beyond 24 months. Benefit payments for Special Conditions are cumulative for the lifetime of the contract.

Pre-Existing Condition Exclusion

3/12, If a person receives medical treatment, or service or incurs expenses as a result of an Injury or Sickness within 3 months prior to the Individual Effective Date, then the Group Policy will not cover any Disability which is caused by, contributed to by, or resulting from that Injury or Sickness; and begins during the first 12 months after the Person's Individual Effective Date.

Credit for the Satisfaction of the Pre-Existing Condition Exclusion Period

This provision applies when a Person moves from an AUL group voluntary disability income insurance plan that provided the Person short term disability coverage similar to his coverage under the Group Policy offered by the Participating Unit. Credit will be given for the satisfaction of the Pre-Existing Condition exclusion period, or portion thereof, already served under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit **IF**:

1. Coverage under the Group Policy is elected by the Employee during the Initial Enrollment Period;
   And
2. The Person changes from one AUL short term disability Plan to another AUL short term disability Plan under this Group Policy during a Scheduled Enrollment Period.

The Person's Individual Effective Date of Insurance under the prior AUL group voluntary short term disability income insurance plan of coverage offered by the Participating Unit will be used when applying the Pre-Existing Condition exclusion or limitation period.

The Group Policy Pre-Existing Condition Limitation will not apply to a Person that was not subject to the prior AUL short term disability plan's Pre-Existing Condition Limitation.

Portability

Once an employee is on the AUL disability plan for 3 months, you may be eligible to port your coverage for one year without evidence of insurability. You have 31 days from your date of termination apply. Please refer to the Mark III website for a copy of your certificate, a claim form, or an application to port form.

Annual Enrollment

Enrollees that did not elect coverage during their initial enrollment are eligible to sign up for $500 or $1000 monthly benefit without medical questions. The maximum benefit cannot exceed 60% of basic monthly earnings.

Exclusions and Limitations

This plan will not cover any disability resulting from certain events or conditions such as but not limited to war, declared or undeclared or any act of war; active participation in a riot; intentionally self-inflicted injuries; commission of an assault or felony; or a pre-existing condition for a specified time period. Additional exclusions and limitations may apply.

Voluntary Long Term Disability Monthly Rates	
Monthly Benefit	**Monthly Deduction**
$500	$6.40
$1,000	$12.80
$1,500	$19.20
$2,000	$25.60

Customer Service
800-553-5318

Disability Claims
866-258-8744

Fax: 207-766-3448

Disability Claims Email: claims@disabilityrms.com

www.employeebenefits.aul.com

This information is provided as a Benefit Outline. It is not a part of the insurance policy and does not change or extend American United Life Insurance Company's liability under the group Policy. Employers may receive either a group Policy or a Certificate of Insurance containing a detailed description of the insurance coverage under the group Policy. If there are any discrepancies between this information and the group Policy, the Policy will prevail.

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Metlife Term Life Plan

Basic Employee Life Insurance

This insurance is payable for death from any cause to any person you name as beneficiary.

Optional Employee Life Insurance

Your employer-sponsored basic life coverage provides important protection for you, but you may need to add to that protection. Now you can...at low group rates and through convenient payroll deductions.

To help meet this need, you have the opportunity to elect additional group life insurance under the optional portion of your program to go along with any personal insurance coverage you may have.

Optional Dependent Life Insurance

Provides coverage on:

- Your Spouse
- Child(ren) from 15 days of age to age 19 (to age 25 if wholly dependent upon you for maintenance and support **and** if enrolled as a full-time student in an accredited school or college). Handicapped children can continue to be covered with no age limit.

It is the responsibility of the employee to notify payroll in writing when a dependent becomes ineligible for coverage. Examples of an ineligible dependent status are divorce, or a child graduates from college.

Accidental Death and Dismemberment

Benefits under this coverage are payable for accidental death or injury as described in your certificate. All active employees have Basic Accidental Death and Dismemberment coverage.

Features

The plan features easy eligibility and simple enrollment procedures. Furthermore, automatic payroll deductions simplify paperwork. This means less bookkeeping for you and no worries about a lapse in coverage due to missed payments.

Increases in coverage, a re-entry in the plan and participants who enroll beyond 31 days of employment will be required to provide evidence of insurability satisfactory to MetLife.

Low Cost

Your cost is lower than for comparable insurance on an individual basis due to the "wholesale" economies inherent in group insurance. Additionally, the System absorbs the cost of administering the program which is underwritten by Metropolitan Life - a leader in the field of group coverage.

Eligibility

You will be eligible for this program if you are a full-time active employee working at least 30 hours per week.

Enrollment

Enrollment is simple - just fill out the election card provided by your employer. Make sure you supply all the required information and return the form where you work. That's all. If a Statement of Health was completed, you will be notified as to when coverage starts.

Beneficiary

You have the right to designate the beneficiary of your choice under employee coverage. You are automatically the beneficiary under Dependent Life.

When Your Insurance Starts

Your Basic Employee Life Insurance becomes effective on the date of your eligibility (the first day of the month after you complete 30 days of continuous employment) if you are then actively at work; otherwise, on the day you return to active work. If you enroll for Optional and/or Dependent Life Insurance on or before you become eligible for coverage, your insurance becomes effective on the date of your eligibility if you are actively at work. If you or a covered dependent are confined in a hospital, not actively at work, or not performing normal daily activities, your insurance will not be effective. You and/or your dependents will become covered when you return to active full-time work, are no longer confined in a hospital, and can perform normal daily activities. Normal daily activities means not confined at home under the care of a doctor for sickness or injury and not entitled to receive any disability income from any source.

If you or any dependents do not satisfy the eligibility requirements described above for date of enrollment and for effective date of coverage, that person will not become insured for Optional Life Insurance until such person has furnished medical evidence of insurability satisfactory to Metropolitan Life.

Termination of Coverage

All insurance under this plan will terminate with the earliest of the following events: termination upon retirement, termination of employment, plan cessation or withdrawal from the plan. Nevertheless, if you should die within 31 days thereafter, your life insurance will still be paid to the beneficiary. If any of your covered dependents should die within such 31 day period, the amount of Life Insurance on account of such dependent will be paid to you.

Extended Death Benefit

This benefit provides that an employee who becomes disabled on or after the effective date of coverage may continue without payment of premium until the earliest of: 12 months from the date of disability; or, beginning with the date of disability, the length of time the employee was covered under the plan plus 31 days, or attainment of age 70.

Conversion

If your employment terminates while you are covered under the plan, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy, issued by Metropolitan Life in any amount up to the amount of your coverage in effect on your date of termination. You must apply for this policy within 31 days after the date your employment terminates. This privilege applies to Optional Dependent Life Insurance as well.

Portability

Portability allows employees whose coverage ends due to certain qualifying events to continue their current (or a lesser) amount of insurance. Portability applies to Employee Optional Life Insurance, not dependents.

Qualifying Events Include:

- Termination of Employment
- Retirement
- Change in employee class which results in the termination of Optional Life Benefits.

The minimum face amount which an employee may elect portability is $20,000. Portable coverage reduces to 50% on January 1st of the year the insured attains age 70 and terminates on January 1st of the year the insured attains age 80. When portable coverage ends, insured individuals have the right to convert to an individual policy.

The accelerated benefit option (ABO)

Metropolitan Life Insurance Company has included an Accelerated Benefit Option (ABO) as part of your group life benefits. Under this option, if you are diagnosed as having a terminal illness, you may be eligible to receive a portion of your group life benefits at such a difficult time. Please refer to your Group Certificate for details.

Suicide Exclusion

No Optional Employee Life or Dependent Life Benefits are payable if you or your dependent(s) commit suicide within two years from the effective date of the coverage.

Claims Procedure

Procedures for Presenting Claims for Benefits - Claim forms needed to file for benefits under the group insurance program can be obtained from your employer. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

If there is any question about a claim payment, an explanation can be requested from MetLife.

Schedule of Benefits

Basic Employee Life Insurance and AD&D *(No cost to you)*

All eligible full-time employees: $10,000

Optional Employee Life Insurance and AD&D

Your choice of the following amounts:

Coverage of $10,000 to $200,000 in $10,000 increments.

Amounts over $100,000 will require medical evidence of insurability*.

Optional Dependent Life Insurance Coverage

**Optional Spouse Life Insurance and AD&D*

Spouse - Increments of $10,000 up to a maximum of $100,000.

Spouse coverage cannot exceed employee coverage.

Amounts over $10,000 require Evidence of Insurability*.

**Optional Child Life Insurance*

Child - Increments of $2,000 to $10,000 per child (No Evidence of Insurability Required)

**Evidence of Insurability is also required for late entrants and anyone increasing their coverage in any amount.*

Optional Dependent Life Insurance is available only to those eligible employees who are insured for Optional Employee Life Insurance. If both husband and wife are employees of the employer only one can cover the dependent children.

This information has been prepared to give you the highlights of additional coverage now being offered by your employer to meet your insurance needs. For details please ask your personnel office or refer to the certificate of insurance that you will receive after you have signed up for protection.

If you have any questions regarding your Statement of Health or Life Insurance claim, please call MetLife at: (800) 638-6420

MetLife Optional Term Life Rates

Rates are based on employee's age at the beginning of each benefit year effective July 1st

Optional Employee & Spouse Term Life and AD&D Monthly Rates											
Amount of Coverage	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
$10,000	$0.95	$0.95	$1.15	$1.55	$1.75	$2.35	$3.65	$5.95	$9.95	$18.45	$29.65
$20,000	$1.90	$1.90	$2.30	$3.10	$3.50	$4.70	$7.30	$11.90	$19.90	$36.90	$59.30
$30,000	$2.85	$2.85	$3.45	$4.65	$5.25	$7.05	$10.95	$17.85	$29.85	$55.35	$88.95
$40,000	$3.80	$3.80	$4.60	$6.20	$7.00	$9.40	$14.60	$23.80	$39.80	$73.80	$118.60
$50,000	$4.75	$4.75	$5.75	$7.75	$8.75	$11.75	$18.25	$29.75	$49.75	$92.25	$148.25
$60,000	$5.70	$5.70	$6.90	$9.30	$10.50	$14.10	$21.90	$35.70	$59.70	$110.70	$177.90
$70,000	$6.65	$6.65	$8.05	$10.85	$12.25	$16.45	$25.55	$41.65	$69.65	$129.15	$207.55
$80,000	$7.60	$7.60	$9.20	$12.40	$14.00	$18.80	$29.20	$47.60	$79.60	$147.60	$237.20
$90,000	$8.55	$8.55	$10.35	$13.95	$15.75	$21.15	$32.85	$53.55	$89.55	$166.05	$266.85
$100,000	$9.50	$9.50	$11.50	$15.50	$17.50	$23.50	$36.50	$59.50	$99.50	$184.50	$296.50
$110,000	$10.45	$10.45	$12.65	$17.05	$19.25	$25.85	$40.15	$65.45	$109.45	$202.95	$326.15
$120,000	$11.40	$11.40	$13.80	$18.60	$21.00	$28.20	$43.80	$71.40	$119.40	$221.40	$355.80
$130,000	$12.35	$12.35	$14.95	$20.15	$22.75	$30.55	$47.45	$77.35	$129.35	$239.85	$385.45
$140,000	$13.30	$13.30	$16.10	$21.70	$24.50	$32.90	$51.10	$83.30	$139.30	$258.30	$415.10
$150,000	$14.25	$14.25	$17.25	$23.25	$26.25	$35.25	$54.75	$89.25	$149.25	$276.75	$444.75
$160,000	$15.20	$15.20	$18.40	$24.80	$28.00	$37.60	$58.40	$95.20	$159.20	$295.20	$474.40
$170,000	$16.15	$16.15	$19.55	$26.35	$29.75	$39.95	$62.05	$101.15	$169.15	$313.65	$504.05
$180,000	$17.10	$17.10	$20.70	$27.90	$31.50	$42.30	$65.70	$107.10	$179.10	$332.10	$533.70
$190,000	$18.05	$18.05	$21.85	$29.45	$33.25	$44.65	$69.35	$113.05	$189.05	$350.55	$563.35
$200,000	$19.00	$19.00	$23.00	$31.00	$35.00	$47.00	$73.00	$119.00	$199.00	$369.00	$593.00

Spouse Rates are based on Employee Age.

*Evidence of Insurability is required on Employee Optional Term Life coverage over $100,000.

*Evidence of Insurability is required on Spouse Term Life coverage amounts over $10,000.

MetLife Optional Child Coverage Monthly Rates					
Amount of Coverage	$2,000	$4,000	$6,000	$8,000	$10,000
Monthly rate	$0.24	$0.48	$0.72	$0.96	$1.20

MetLife®

Texas Life Whole Life Insurance - Solutions 121

Common Issue Date: August 1, 2016

An ideal complement to any group term and optional term life insurance your employer might provide, Texas Life's SOLUTIONS 121 is the life insurance you keep, even when you change jobs or retire as long as you pay the premiums. It will help protect your family, both today and, more importantly, tomorrow. Even better, you won't even have to pay for it after age 65 (or 20 years if you're 46 years of age or older), because it's guaranteed to be paid up.[1]

SOLUTIONS is an individual permanent life insurance product specifically designed for employees and their families. These policies provide a guaranteed level premium and death benefit for the life of the policy, and all you have to do to qualify for basic amounts of coverage is be actively at work the day you enroll. You also may apply for coverage on your spouse, children and grandchildren with limited underwriting requirements.

As an employee, you are eligible to apply once you have satisfied your employer's eligibility period. [2]

Why Voluntary Coverage?

- Most employees typically depend on group term life insurance.
- Today more adults than ever have only group life insurance obtained through their employers, but they carry the lowest average amounts of coverage.[3]
- On the other hand, adults with both individual life and group life policies have the most life insurance protection.[3]
- Most term policies generally expire before paying a death claim.
- When do you want a life insurance policy in force? --Answer: When you die.
- Term is for IF you die, permanent is for WHEN you die.

The SOLUTIONS Advantage

Individual Protection

SOLUTIONS 121 is a permanent life insurance policy that you own; it can never be canceled, as long as you pay the guaranteed level premiums due, even if your health changes. Because you own it, you can take SOLUTIONS 121 with you when you change jobs or retire with no change in the premium.

Coverage for Your Family

You may also apply for an individual SOLUTIONS 121 policy for your spouse/domestic partner, dependent children ages 15 days - 26 years and grandchildren ages 15 days -18 years, even if you do not apply for coverage.[2]

Paid Up Insurance

SOLUTIONS 121 has premiums that are guaranteed to remain level until your age 65 or for 20 years if you purchase the policy after age 45. At that time, the policy becomes fully paid up; no further premiums are due, and the death benefit does not reduce. This gives you the peace of mind that comes with life insurance that's paid for as your income changes in retirement.

Convenience of payroll deduction

Thanks to your employer, SOLUTIONS 121 premiums are paid through convenient payroll deductions and sent to Texas Life by your employer.

Portable, Permanent

You may continue the peace of mind SOLUTIONS 121 provides, even when you change jobs or retire. Once your policy is issued, the coverage is yours to keep. If you should change jobs or retire before the policy becomes paid up, you simply pay the monthly premium directly to Texas Life by automatic bank draft or monthly bill (for monthly bill we may add a billing fee not to exceed $2.00). Premiums are guaranteed to remain level to your age 65, or for 20 years if you purchase the policy after age 46, when the policy is fully paid-up and your death benefit reduces to a percentage of the initial face amount.

Accelerated Death Benefit due to Terminal Illness

For no additional premium, the policy includes an Accelerated Death Benefit Due to Terminal Illness Rider. Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92.6% (92% in CA, CT, DC, DE, FL, ND & SD) of the face amount, minus a $150 ($100 in Florida) administrative fee in lieu of the insurance proceeds otherwise payable at death. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. (Conditions apply)

Accelerated Death Benefit for Chronic Illness

Included in the policy at the option of the employer, the Accelerated Death Benefit for Chronic Illness rider covers all applicants. If an insured becomes permanently chronically ill, meaning that he/she is unable to perform two of six Activities of Daily Living (such as bathing, continence, or dressing), or is severely cognitively impaired (such as Alzheimer's), he/she may elect to claim an accelerated death benefit in lieu of the Face Amount payable at death. The single sum payment is 92% of the Face Amount less an administrative fee of $150 ($100 in FL). The Accelerated Death Benefit for Chronic Illness Rider premiums are 8% of the base policy premium. Conditions and limitations apply. See the SOLUTIONS 121 Pamphlet for details. (Policy form ULABR-CI-14 or ICC14-ULABR-CI-14.)

Waiver of Premium Rider

This benefit to age 65 (issue ages 17-59) waives the premium after six months of the insured's total disability and will even refund the prior six months' premium. Benefits continue payable until the earlier of the end of the insured's total disability or age 65. Cost is an additional 10% of the basic monthly premium. Self-inflicted or war-related disability is excluded. Notice, proof and waiting period provisions apply. Form ICC07-ULCL-WP-07 and Form Series ULCL-WP-07.

Coverage begins immediately

Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply (one year in ND).

Sample Rates

The chart below displays examples of SOLUTIONS 121 rates at varying ages for a $50,000 policy. Rates shown below for both non-tobacco and tobacco users, and include the cost for Waiver of Premium and the Accelerated Death for Chronic Illness benefit.

Solutions 121				
Age	**Face Amount**	Monthly Premium **Non-Tobacco Chronic Illness Waiver**	Monthly Premium **Tobacco Chronic Illness Waiver**	**Paid-up Age**
20	$50,000	$38.11	$46.96	**65**
25	$50,000	$43.42	$54.63	**65**
30	$50,000	$53.45	$67.02	**65**
35	$50,000	$68.20	$86.49	**65**
40	$50,000	$91.80	$115.40	**65**
45	$50,000	$125.43	$162.01	**65**

SOLUTIONS Review

- Permanent and yours to keep when you change jobs or retire
- Non-participating Whole Life (no dividends)
- Guaranteed death benefit [1]
- Guaranteed level premium
- Guaranteed paid-up insurance at age 65, or for 20 years if the policy is purchased after age 45
- If you're actively at work the day you enroll, you can qualify for basic amounts with no more underwriting.
- Includes Accelerated Death Benefit for Chronic Illness
- Waiver of Premium included for ages 17-59
- If you desire more coverage, you can qualify by answering just four underwriting questions.
- Coverage available for spouse, children and grandchildren[2]

If you have any questions regarding your Texas Life policy, please call 800-283-9233, prompt #2

[1] Guarantees are subject to product terms, exclusions and limitations and the insurers claims-paying ability and financial strength.

[2] Coverage and spouse/domestic partner eligibility may vary by state. Coverage not available for children and grandchildren in Washington. Texas Life complies with all state laws regarding marriages, domestic and civil union partnerships and legally recognized familial relationships.

[3] Facts About Life, LIMRA International (2011)

TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

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See the SOLUTIONS brochure for complete details.
Policy form WLOTO-NI-11 or ICC11-WLOTO-NI-11

Need help with healthcare?

We've got your lifeline.

Introducing Health Advocacy, Medical Bill Saver™ and Telemedicine services, now part of your Aflac plan.

We've enhanced your plan without adding cost.

Now, if you have Aflac Group Critical Illness, Group Accident or Group Hospital Indemnity policies, you also have access to three new services that make it easier to access care, reduce out-of-pocket medical expenses and navigate the healthcare system with greater ease:

- **Get answers and expert help** with Health Advocacy from Health Advocate.
- **Let advocates negotiate** your medical bills with Medical Bill Saver™, also from Health Advocate
- **Connect with health providers** via phone, app or online with MeMD.

SERVICES AVAILABLE
STARTING
JANUARY 1, 2016

These three services are now embedded in your group plan — at no extra charge. Best of all, you can start using them as soon as your Aflac coverage starts.

Start using Health Advocacy and Medical Bill Saver™ from Health Advocate and Telemedicine from MeMD January 1, 2016.

Questions? Call **855-423-8585**

DID YOU KNOW?

You can also use Health Advocate's Health Advocacy and Medical Bill Saver™ services for your spouse, dependent children, parents and parents-in-law, while Telemedicine is available for you and your family.

HealthAdvocate MeMD Aflac

Get more without spending more.

More than just peace of mind.
Health Advocacy from Health Advocate

You have 24/7 access to Personal Health Advocates who start helping from the first call:

- Find doctors, dentists, specialists, hospitals and other providers
- Schedule appointments, treatments and tests
- Resolve benefits issues and coordinate benefits
- Assist with eldercare issues, Medicare and more
- Help transfer medical records, lab results and X-rays
- Work with insurance companies to obtain approvals and clarify coverage

More than just cash benefits.
Medical Bill Saver™ from Health Advocate

Aflac already pays claims quickly. Now, with Medical Bill Saver™, Health Advocate professionals also help you negotiate medical bills not covered by health insurance:

- Just send in your medical and dental bills of $400 or more
- They contact the provider to negotiate a discount
- Negotiations can lead to a reduction in out-of-pocket costs
- Once an agreement is made, the provider approves payment terms and conditions
- You get an easy-to-read personal Savings Result Statement, summarizing the outcome and payment terms

More than just care.
Telemedicine from MeMD

You can quickly connect with board-certified, U.S. licensed health providers online for 24/7/365 access to medical care — fast:

- Create your account at www.MeMD.me
- When you have a health issue, log on and request a provider consultation
- You can request consultations via webcam, app or phone
- Get ePrescriptions,* referrals and more
- Use it for a range of health issues, from allergies and colds to medication refills
- $35.00 per visit!

Questions? Call **855-423-8585**

*When medically necessary, MeMD providers can submit a prescription electronically for purchase and pick-up at your local pharmacy.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. Continental American Insurance Company | 2801 Devine Street | Columbia, South Carolina 29205

1500186

IV (9/15)

Continuation of Benefits Options If You Leave Your Employment with Randolph County Government

CIGNA Medical Plans

Under the group medical plan, you and your covered dependents are eligible to continue medical coverage through COBRA if you experience certain "qualifying events".

If you and your dependents are enrolled in the medical plan, you will be eligible to continue coverage through COBRA after you leave your employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue medical coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. For more information, call **FBA at (800) 437-3539.**

Medical Reimbursement Account:

Under the Flexible Benefit Administrators Medical Spending Account plan, you are eligible to continue coverage through COBRA.

If you are enrolled in the Medical Reimbursement Account, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. You will receive notification from Flexible Benefit Administrators (FBA) with your account balance and continuation options shortly following your termination of employment. You may call **FBA at 1-800-437-3539.**

Ameritas Dental:

Under the dental plan, you and your covered dependents are eligible to continue dental coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the dental plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents maybe eligible to continue dental coverage through COBRA. Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child ages out of the plan. You will receive notification from Flexible Benefit Administrators (FBA) with premium and continuation options shortly following your termination of employment or you may call them at **1-800-437-3539.**

Superior Vision:

Under the Superior Vision plan, you and your covered dependents are eligible to continue vision coverage through COBRA according to the following "qualifying events".

If you and your dependents are enrolled in the vision plan, you will be eligible to continue coverage through COBRA after you leave employment for a specified period. In addition, while covered under the plan, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be eligible to continue vision coverage through COBRA.

Also, while you are covered under the plan, your covered children who no longer qualify as an eligible dependent may continue coverage through COBRA. Examples of an ineligible dependent would be when your child ages out of the plan. For more information, call **Flexible Benefit Administrators at 1-800-437-3539.**

Aflac Accident and Critical Illness Plans

You may continue your policy(ies) by having the premiums currently deducted from your paycheck drafted from you bank account or billed to your home. For more information, contact **Aflac/CAIC at 1-800-433-3036**

AUL Short and Long Term Disability Plans

Once an employee is on the AUL disability plan(s) for 3 months, you can port the coverages for one year at the same cost without evidence of insurability. You have 30 days from your date of termination to contact AUL to port your coverage by calling **1-800-553-5318.**

Allstate Cancer Plan

Allstate Benefits will provide portability coverage providing you send a written request and payment of the first premiums for the portability coverage not later than 63 days after termination. For details call **Allstate at: 1-800-521-3535**

Texas Whole Life

When you leave employment, you may continue your Texas Life Whole Life coverage by having the premiums that are currently deducted from your paycheck billed to your home address or drafted from your bank account. You may do that by contacting **Texas Life at: 1-800-283-9233 prompt #3.**

Metlife Term Life

Conversion: If your employment terminates while you and/or your dependents are covered under the plan or when your Extended Death Benefit period is over, you may purchase without medical evidence of insurability, any individual insurance policy, except a term policy. You must apply for conversion within **30** days after the date your or your dependents' coverage terminates. I**t is the responsibility of the employee to contact Metlife if you wish to pursue the conversion option. You may do so by calling 1-877-275-6387.**

Portability: If you terminate employment, the portability provision allows you to take your **Optional life** coverage with you, subject to the following provisions:

- You must apply for coverage within 31 days from the date your employment terminates.
- You must be ACTIVELY at work prior to employment termination.
- You may only port up to your current coverage amount. You cannot increase or add dependents.
- Employees are eligible to age 74, spouses to age 64 and children up to age 18, 24 if a full-time student.

It is the responsibility of the employee to contact MetLife if you wish to port your current coverage. You may do so by calling 1-877-275-6387.

If you do not convert or port your group term life insurance, coverage will terminate.

Important Phone Numbers

Flexible Benefit Administrators - 1-800-437-FLEX (3539)

Ameritas Life (Dental) - 1-800-487-5553

Superior Vision - 1-800-507-3800

Continental American (CAIC - Accident) - 1-800-433-3036

Allstate Life (Cancer) - Customer Service: 1-800-521-3535

Assurity Life (Old Cancer Policy) - Customer Service: 1-866-289-7337
To Call in a Wellness Claim: 1-888-358-8808, ext. 23
To Fax in a Wellness Claim: 1-800-869-0368

American United Life (Disability)
Customer Service: 1-800-553-5318
Claims: 1-866-258-8744

MetLife (Term Life)
Customer Service - 1-800-638-6420
Conversion/ Portability - 1-877-275-6387

Texas Life (Whole Life) - 1-800-283-9233

MetLife Whole Life (Old Whole Life Coverage) 1-800-634-5007

Mark III Employee Benefits: 1-800-532-1044, Ext. 212

To Download Claim Forms go to the
Randolph County Government/ Mark III Website:

www.markiiibrokerage.com/randolphcountync

Benefits available to Retirees of North Carolina State and Local Governments

MetLife Dental and Superior Vision Insurance Plans for Retirees of State or Local Government Offered Through North Carolina Retired Governmental Employees' Association, Inc.

With over 54,000 members, the North Carolina Retired Governmental Employees' Association is the largest single group representing retirees before the N.C. General Assembly, the Retirement Systems Boards of Trustees, and the State Health Plan trustees. For retirees or future retirees of state or local governments in North Carolina (including teachers, legislators, National Guard, and judicial), NCRGEA is your voice for sustaining and increasing your benefits after retirement.

Additionally, there are many benefits included with membership at no additional cost ($10,000 AD&D Insurance, bimonthly newsletter, weekly electronic legislative updates while the General Assembly is in session, a toll-free number to call for information and assistance, hearing assistance and vision care discount programs, and free district meetings).

The Association also offers optional MetLife Dental Insurance and Superior Vision Insurance plans for our members. Those premiums are conveniently deducted from your retirement benefit check monthly. Please contact us at NCRGEA, PO Box 10561, Raleigh, NC 27605, 1-800-356-1190, or go to our website, **www.ncrgea.com**, for further information.

View Benefit Information & Download Forms at:

www.markiiibrokerage.com/randolphcountync

or scan:

Mark III

Employee Benefits

211 Greenwich Road
Charlotte, NC 28211

(800) 532-1044
(704) 365-4280